



MLTSS Program Improvements through Innovation, Quality Measurement and Evaluation

2015 HCBS Conference

Camille Dobson
Deputy Executive Director

8/31/2015

www.nasuad.org

What is Managed Long-Term Services and Supports (MLTSS)?

- MLTSS is the delivery of long term services and supports (either state plan or waiver services) through capitated Medicaid managed care plans
- In many cases, plans are covering medical services as well, which provides a comprehensive delivery system for beneficiaries

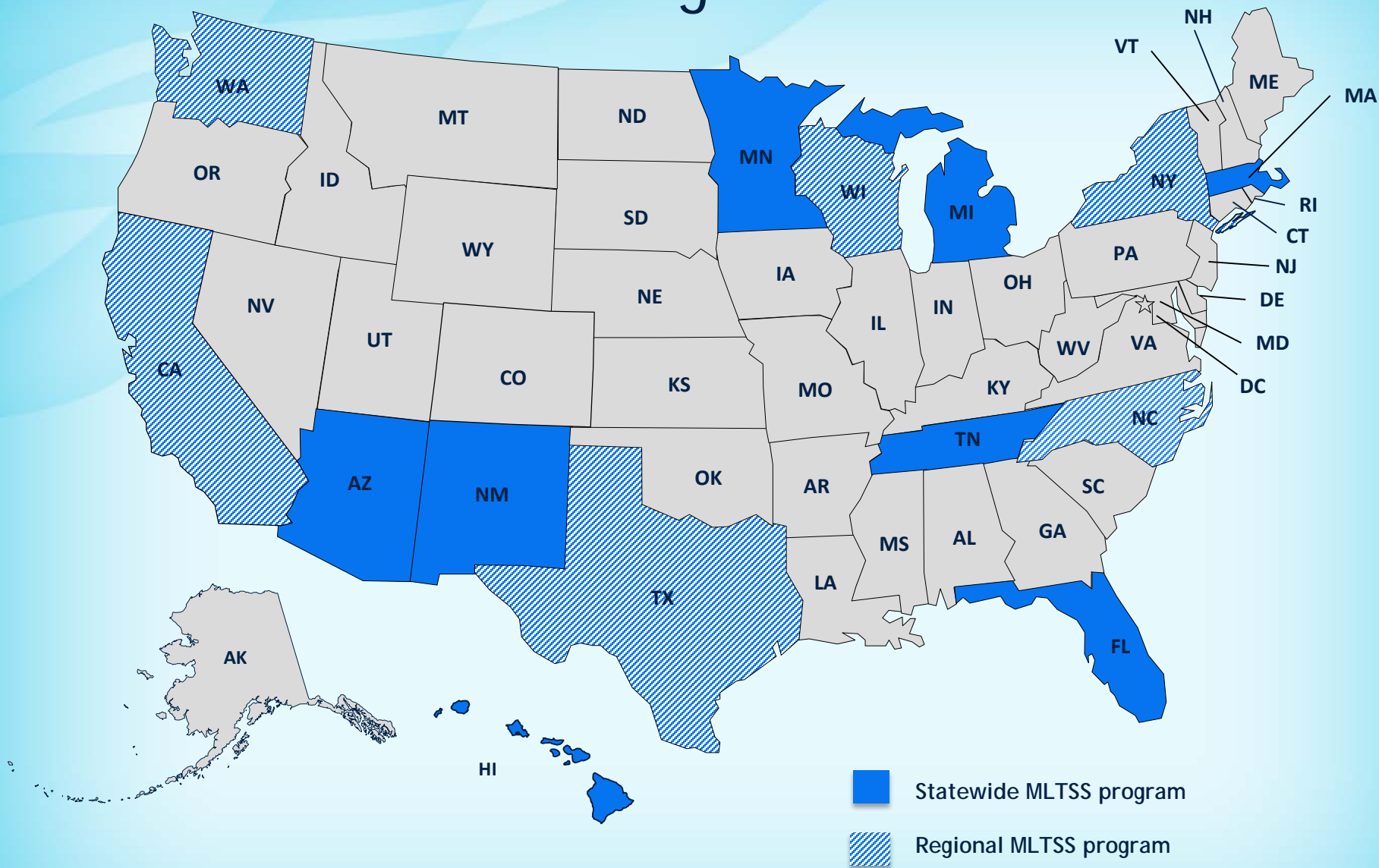
Why are states pursuing MLTSS?

- In FFY 2013, LTSS expenditures represented about 34% of all Medicaid expenditures (~\$146B) (Source: Truven Health Analytics, June 2015)
 - Of note: managed care expenditures increased by 44% from FY 2012 (to almost 10% of all LTSS expenditures)
- Accountability for beneficiary outcomes (both acute and LTSS) rests with a single entity
 - Coordination across both health and social services has great potential to improve health and quality of life, and lower overall costs.

Why are states pursuing MLTSS?

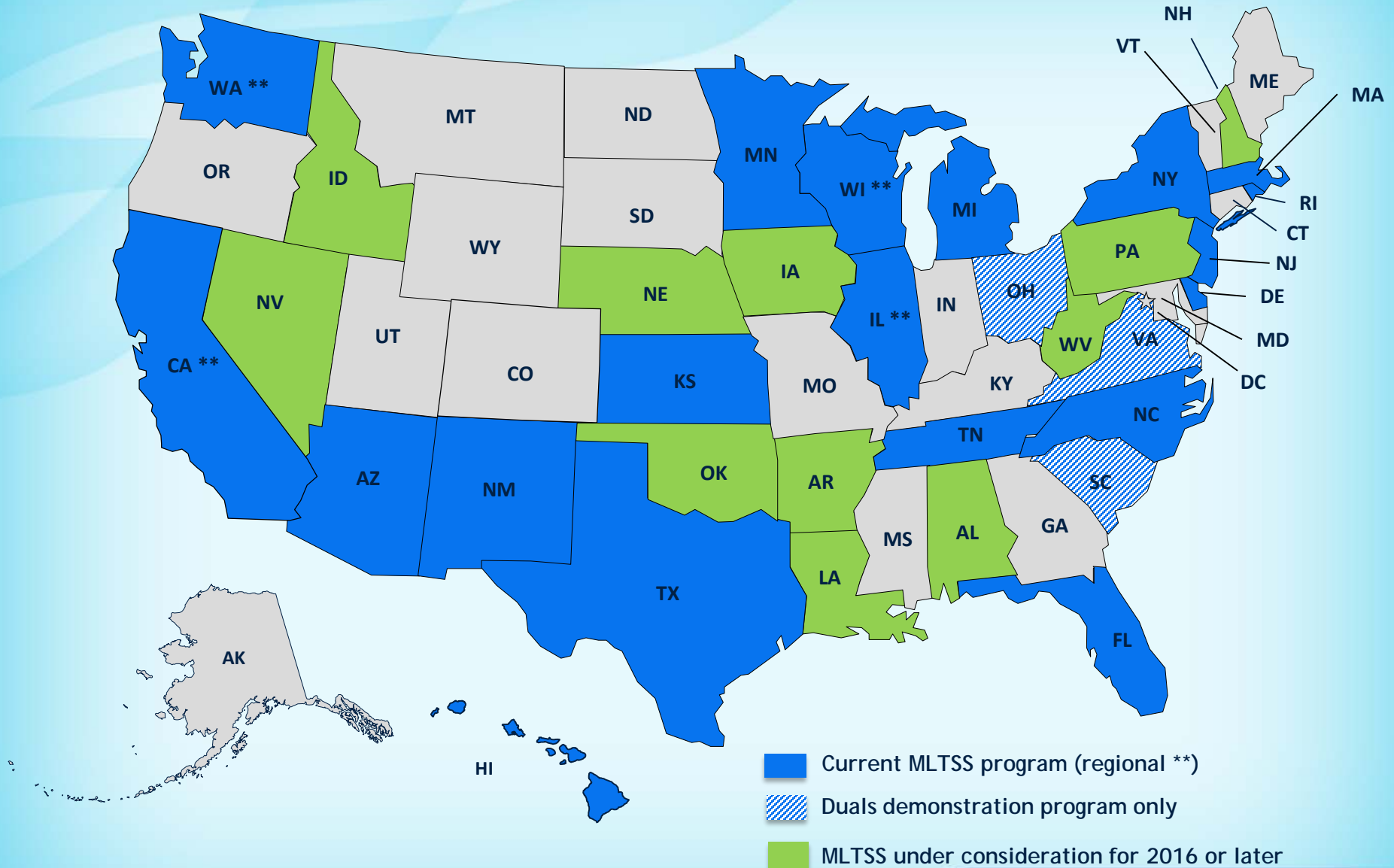
- Managed care payments provide budget predictability for states
- Potentially can provide more HCBS services to beneficiaries on waiting lists
- Plans have incentives to provide care in least restrictive/most cost-effective settings
- Plans may speed rebalancing by contracting and reimbursement practices with providers

MLTSS Programs - 2010



Source: Truven Health Analytics, 2012

MLTSS Programs - 2015



Source: NASUAD State of the State Survey

Context for today's intensive

- MLTSS programs are not static
- Improvement happens through innovation and introspection
- Where are MLTSS programs headed?
- How do states know how their programs are performing?

Context for today's intensive

- Goal for intensive: Share a 'deep dive' into MLTSS program innovations and how national studies, state evaluations and quality measurement help drive MLTSS program improvements
- Outcome of intensive: Leave with greater understanding of quality landscape and how states are making improvements in their MLTSS programs



For more information, please visit: www.nasuad.org

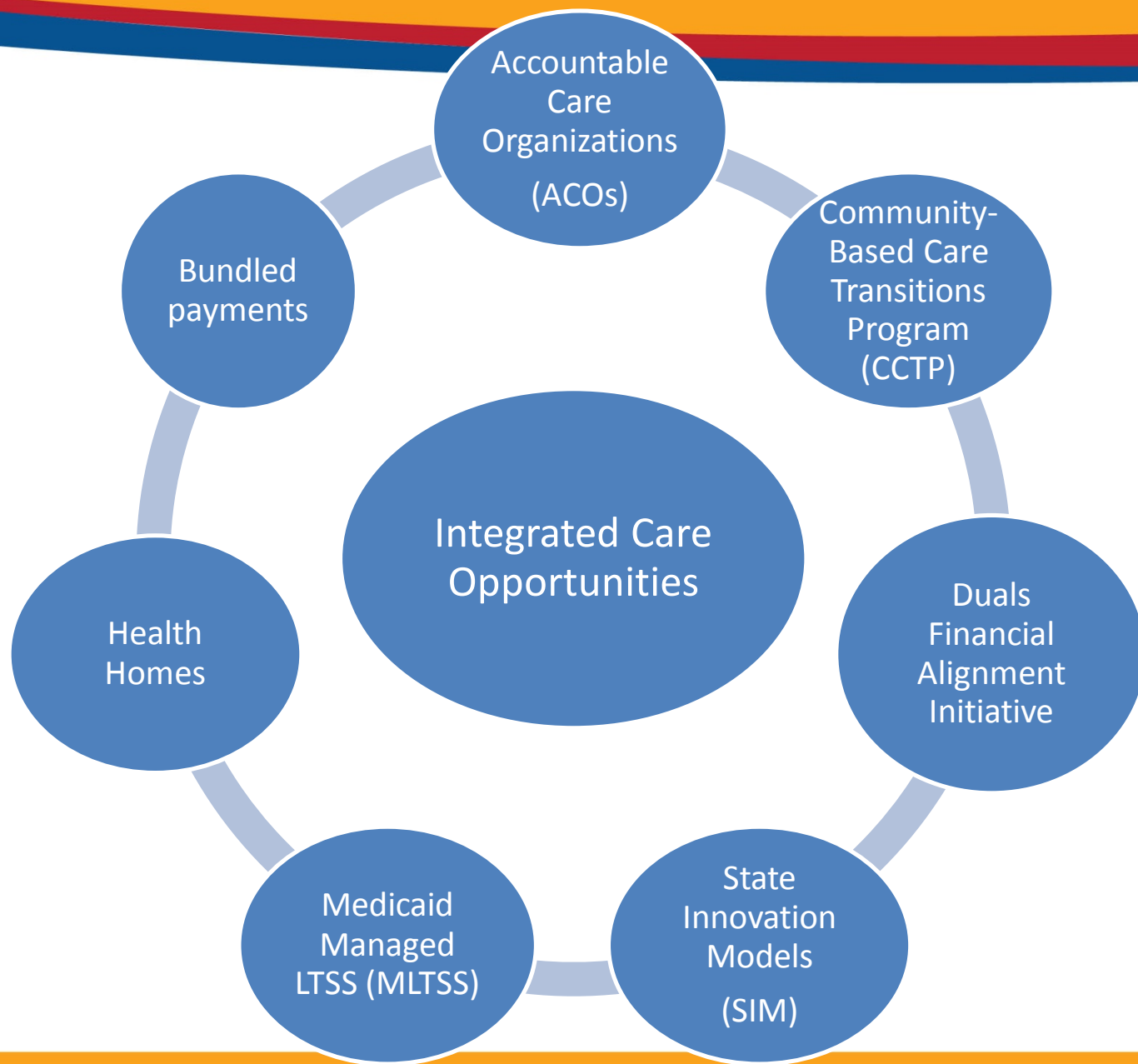
Or call us at: **202-898-2583**



Integrated Care and the Aging & Disability Networks: Where Are We Now?

Marisa Scala-Foley

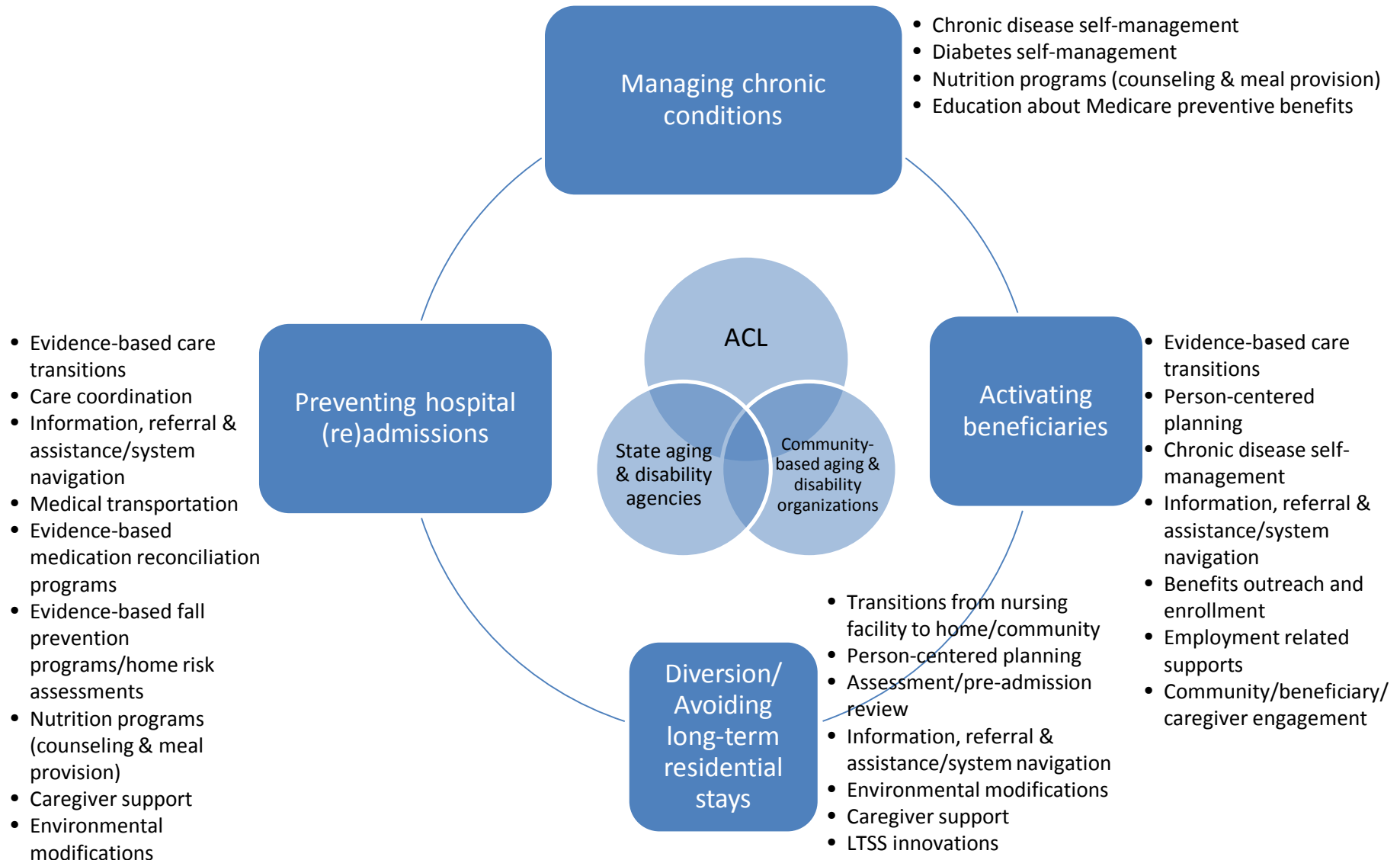




Key Questions



Where do our networks fit in?



For integrated care entities...

Build
it

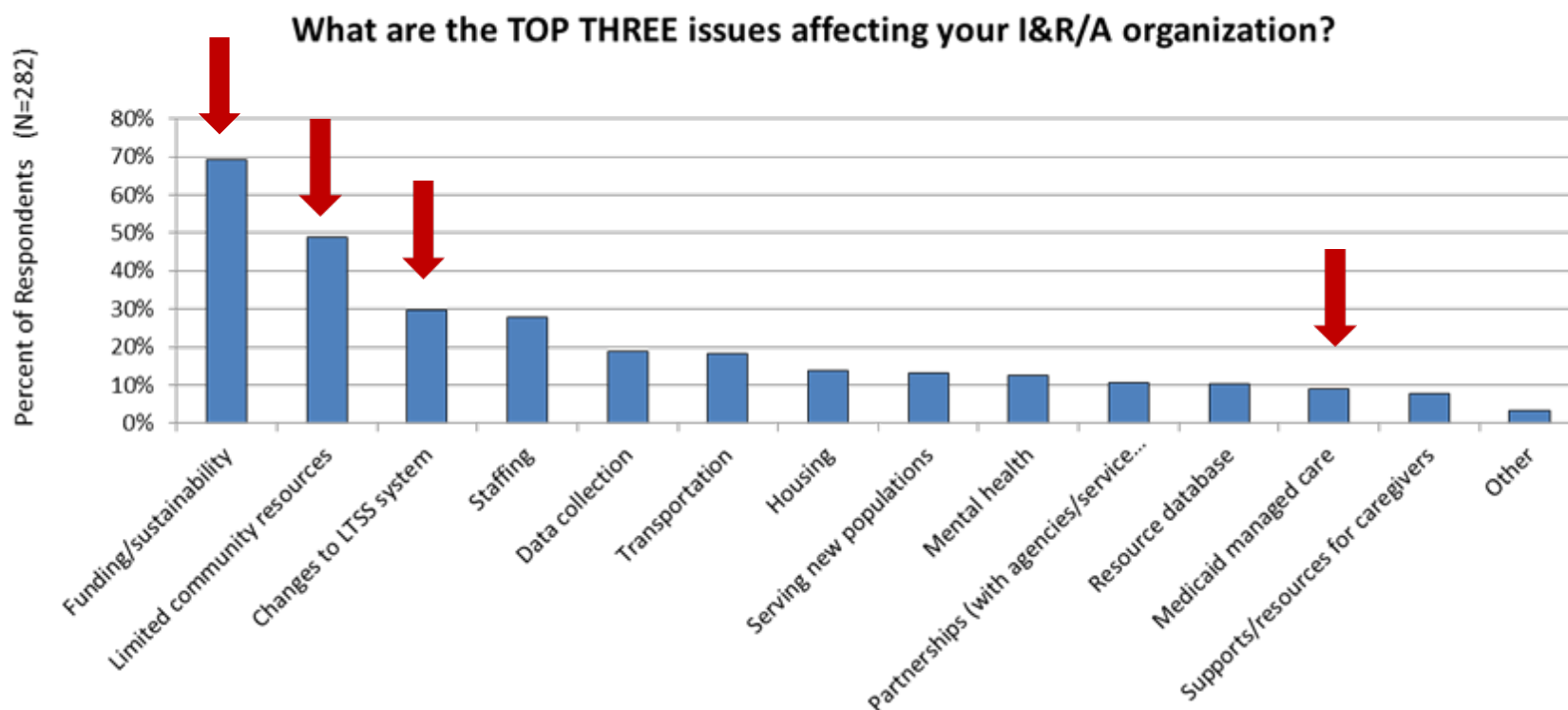


Buy
it



Why does this work matter to aging and disability organizations?

Concerns about sustainability & systems changes



Source: Aging and Disability 2015 Information & Referral/Assistance National Survey, National Association of States United for Aging and Disabilities (NASUAD) in partnership with the National Council on Independent Living (NCIL)

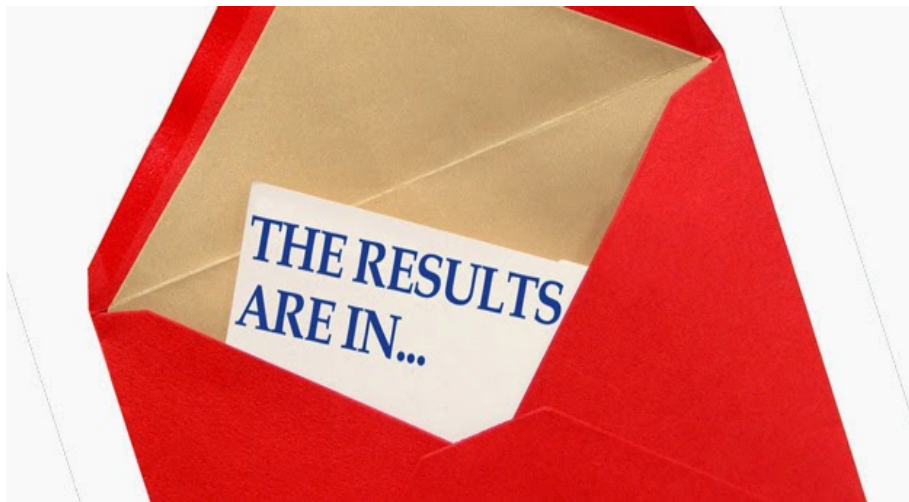


Why else?

Bottom-line:

If we don't do this, someone else will.

ACL Business Acumen Learning Collaboratives



- *2013-14*: 9 CBO networks, 17 signed contracts, 1 MSO formed, 1 network LLC under formation, 1 organization accredited by NCQA for care management
- *2015*: 11 networks, 2 signed contracts (thus far), 2 under negotiation, 1 network LLC under formation

About the contracts

- *Most common services:* Care transitions*, in-home assessment and medication reconciliation, care coordination & navigation, evidence-based programs (EBP)
- *Most common contracting organizations:* duals plans*, Accountable Care Organizations, Medicaid health plan, physician group, state healthcare exchange



What we've learned

- Culture matters
- Relationships (and champions) are critical to the process
- Contracts take TIME
- CBOs need to match their strengths with payers' needs
- Infrastructure to deal with “back office” functions (e.g., billing, tracking outcomes, information technology) is as important – if not more important – as pricing
- Still many issues that need more work: Network service quality, performance measurement, information technology, accreditation, finding more champions within the health care sector, and more

Achieving balance

- Margin and mission
- Accreditation and overmedicalization
- Traditional partnerships and MOUs
- Aging and disability



What's next?

- New HHS delivery system reform goals:
 - Alternative Payment Models (e.g., ACOs, bundled payment arrangements):
 - ✓ 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016
 - ✓ 50% by the end of 2018
 - Linking FFS Payments to Quality/Value (e.g., Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs):
 - ✓ 85% of all Medicare fee-for-service payments tied to quality or value by 2016
 - ✓ 90% by the end of 2018
- “Capture and spread” learnings from business acumen efforts to larger field of aging and disability organizations
- Continue development of public-private partnerships

New opportunities (and challenges)

- Increasing recognition of importance of social determinants of health
 - ✓ Good for our networks...but also brings out competition
- Getting the contracts may just be the easy part
 - ✓ Dealing with conflict of interest, volume/scaling, IT, data access, performance measurement/management
- Increasing number of champions:
 - ✓ Foundations
 - ✓ Health-care sector
- Increasing network readiness for delivery system reform

Gaining some traction

“For these individuals [with both chronic conditions and functional limitations requiring long-term services and supports] to achieve better health, providers must be able to connect their patients to social supports and human services while focusing on prevention and wellness in ways that emphasize behavior change. By partnering with community-based organizations (CBOs), such as Area Agencies on Aging (AAAs), providers can help individuals manage their chronic diseases and meet their often overlooked social needs.”

Dr. Anand Parekh & Dr. Robert Schneider

“How Community-Based Organizations Can Support Value-Driven Health Care”

Health Affairs, July 10, 2015

<http://healthaffairs.org/blog/2015/07/10/how-community-based-organizations-can-support-value-driven-health-care/>

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<http://www.acl.gov/Programs/CIP/OICI/BusinessAcumen/index.aspx>



Setting the Stage: Federal and State Efforts in MLTSS Quality Measurement

Camille Dobson
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8/31/2015

www.nasuad.org

Quality - what is it?

- Typical description - “the right care at the right time in the right setting”
- Does that work for long-term services and supports? It can....
- For health plans, quality = value for investment
- Quality can be defined using different types of measures
 - Structure measures, e.g., provider qualifications
 - Process measures, e.g., screening for diabetes
 - Outcome measures, e.g., increased level of functioning

Quality measures in LTSS

- Mostly focused on medical care (HEDIS®)
 - Reduced hospitalizations
 - Reduced ER visits
 - Improved management of chronic conditions
- These ARE important but what about the rest?
Majority of LTSS are non-medical services
- What does “quality” mean for a meal provider? or homemaker/chore services? Or personal care services
- Much more difficult to measure

Quality measures in LTSS

- No national measure set (like HEDIS®) so states and providers have been innovators
- Starting point can be 1915(c) waiver performance measures
- Primarily compliance activities consistent with the waiver application with a few structure and process measures, such as
 - Timely assessments
 - Providers trained in accordance with waiver specifications
 - #/% of care plans that reflect identified needs and goals

Quality measures in LTSS

- These compliance measures generally don't get to the delivery of services and how consumers experience them
- True 'outcomes' measures are limited because defining the outcome is challenging
 - Quality of life?
 - Independence, inclusion, relationships?
 - Choice?

State Efforts to Measure Quality

- Consumer Surveys
 - National Core Indicators: quality of life in-person survey to individuals with intellectual/developmental disabilities (www.nationalcoreindicators.org)
 - Measures domains such as
 - 45 States
 - Associated surveys for family members and support staff
 - National Core Indicators - Aging and Disabilities: quality of life in-person survey to older adults and persons with disabilities receiving publicly-funded services (OAA, Medicaid, state-only) (<http://www.nasuad.org/initiatives/national-core-indicators-aging-and-disabilities>)
 - 14 States
 - 4 States oversampling MCO enrollees to draw conclusions about MCO performance

State Efforts to Measure Quality

- Consumer Surveys (in collaboration with CMS)
 - Participant Experience Surveys
 - Developed by CMS specifically for HCBS waiver participants
 - Home and Community-Based Service (HCBS) Experience Survey (TEFT)
 - 9 states field-testing a consumer survey that CMS intends to submit for CAHPS™ inclusion
 - Intended for
 - MFP Quality of Life Survey
- MLTSS Contract Requirements
- Waiver Quality Assurances



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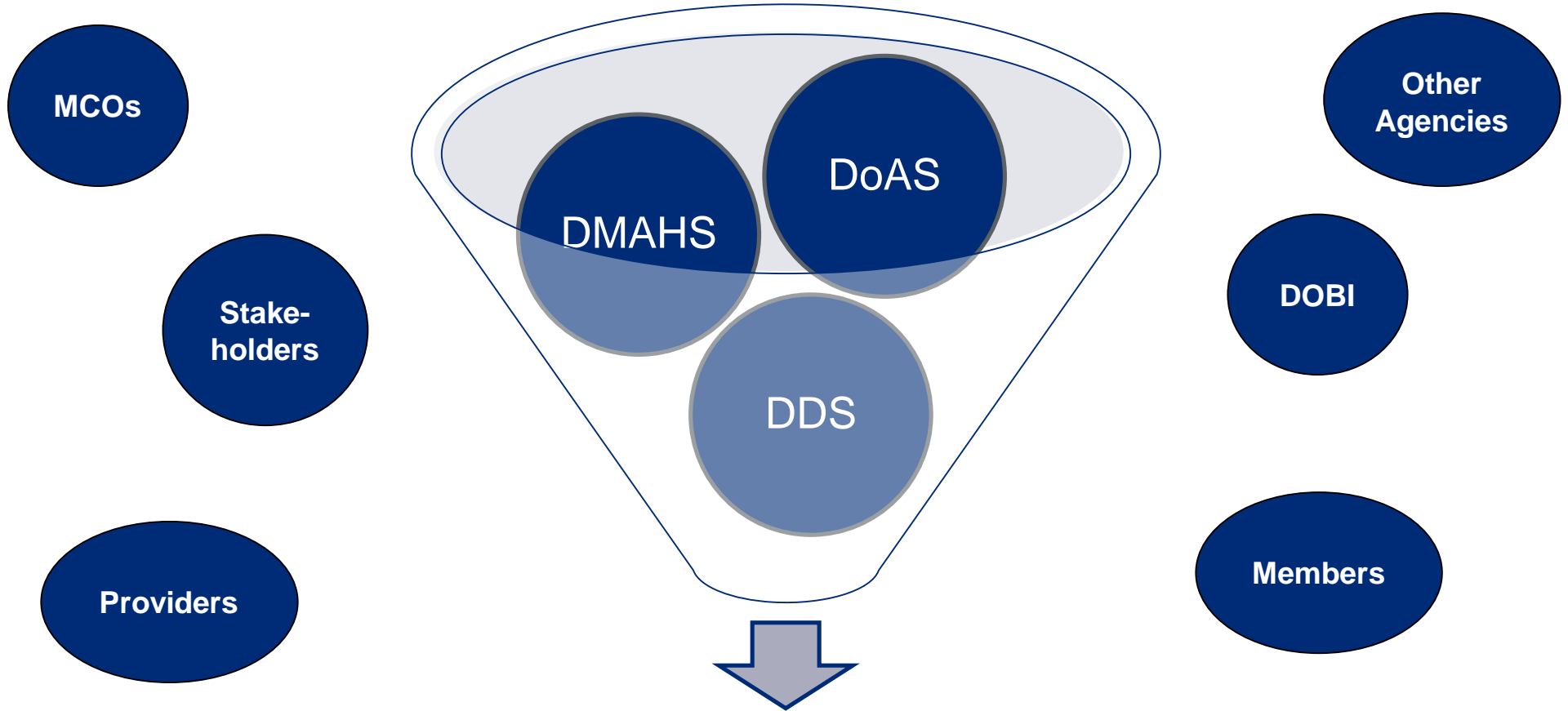
Developing an MLTSS Quality Enterprise

THE NEW JERSEY EXPERIENCE

August 31, 2015

Lowell Arye, Deputy Commissioner, Department of Human Services
Alan Schafer, Mercer
Wendy S. Woske, Mercer

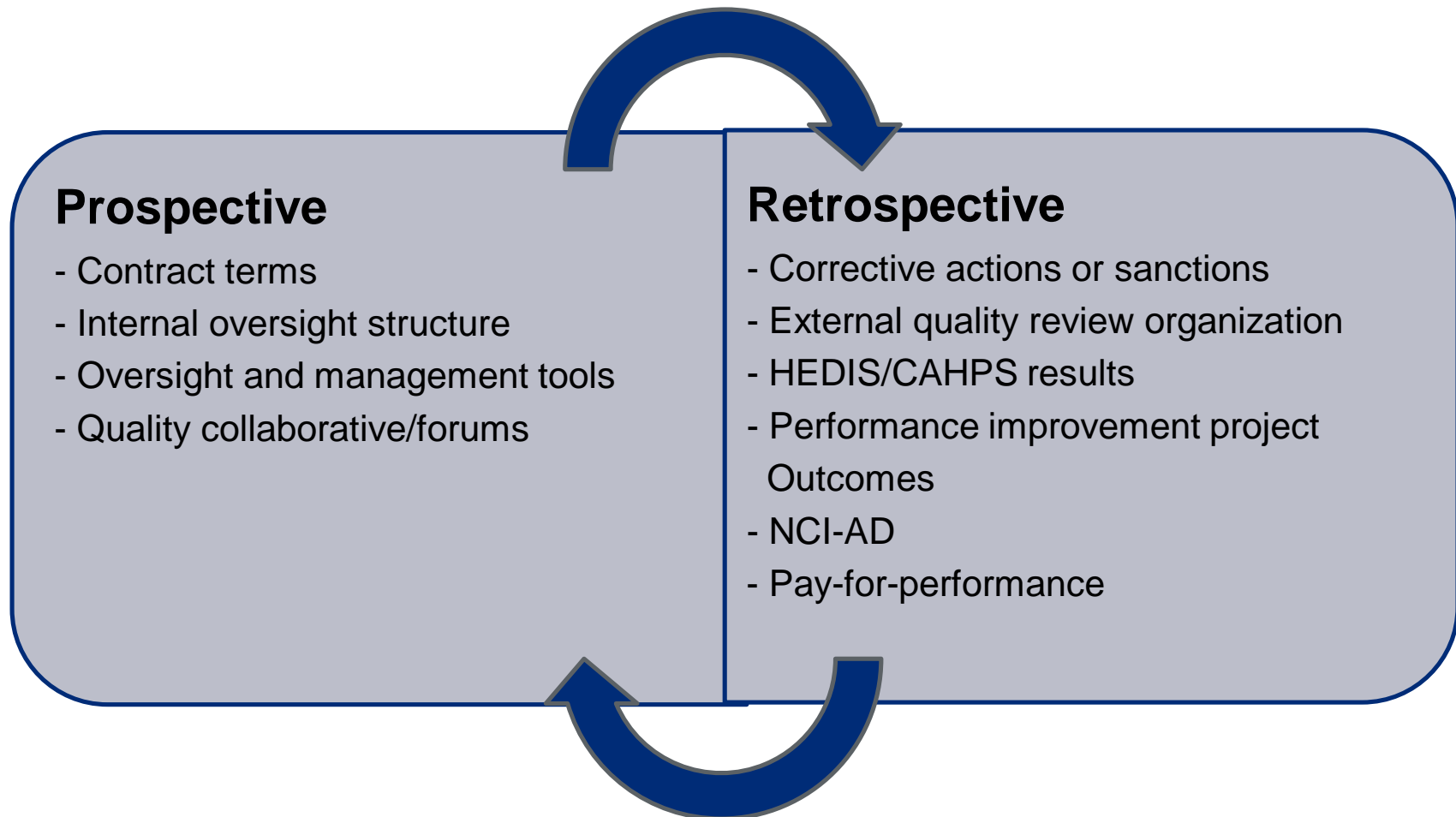
A Pathway to Quality State Readiness Review



Comprehensive MLTSS Quality Enterprise

A Pathway to Quality

Integrating HCBS quality framework into managed Medicaid quality strategy



New Jersey's NCI-AD Project

- To assess the performance of NJ's funded LTSS programs and how they impact the quality of life and outcomes of service recipients.
 - Focuses on performance of NJ's LTSS systems instead of specific services.
 - Provides data on LTSS regardless of funding source (Medicaid, PACE, Older Americans Act).
- To compare NJ's LTSS recipients on a National level — how does NJ compare with other State's?
- In-person surveys to a sampling of recipients of long-term services and supports.

MLTSS Pay for Performance Measures

Level of Care Assessment Prior to Enrollment

Complaint/Appeal/Grievance Reviews Completed in 30 Days

Plan of Care Established within 30 Days of Enrollment

of MLTSS Members Moving from Nursing Facilities to Community

Plans of Care Aligned with Member's needs based on the NJ Choice Assessment

MLTSS/HCBS Member Hospital Readmissions within 30 Days

Compliance with Contractual Provider Network Standards

Emergency Room Utilization by MLTSS HCBS Members

Reporting of Critical Incidents within required timeframe

Follow up with MH Professional within 7 Days of Hospitalization for Mental Illness



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STATE OF TENNESSEE

Driving MCOs to Improve Quality

August 31, 2015
HCBS Conference



MLTSS in Tennessee

- Managed care demonstration implemented in 1994
- Operates under the authority of an 1115 waiver
- *Entire* Medicaid population (1.4 million) in managed care
- Three at-risk NCQA accredited MCOs (statewide in 2015)
- Physical/behavioral health integrated beginning in 2007
- LTSS for seniors and adults w/ physical disabilities in 2010
- MLTSS program is called “*CHOICES*”
- State sets rates of reimbursement for all LTSS (NF and HCBS)
- ICF/IID and 1915(c) ID waivers carved out; populations carved in
- New proposed MLTSS program component for I/DD for 2016: *Employment and Community First CHOICES*

Quality in Tennessee's MLTSS Program

- Integrated quality strategy
- Special study components
- Baseline data plan
- Uniform measures of system performance
- Detailed reporting requirements
- Ongoing audit and monitoring processes
- Measures to immediately detect and resolve problems, including gaps in care
 - Electronic Visit Verification
- Independent review (External Quality Review Organization, Tennessee Department of Commerce and Insurance)
- **Focus on member perceptions of quality**
 - QOL/Member satisfaction survey
 - Consumer advisory groups

A Definition of Quality in MLTSS:

Providing the right care
in the right place
at the right time—
with the best possible outcome that helps people
live the lives they want to live

—The Agency for Healthcare Research and Quality (AHRQ), *modified*

Quality Improvement in Long-Term Services and Supports (QuILTSS)

- A TennCare initiative to promote the delivery of high quality LTSS for TennCare members (NF as well as HCBS)
- Identify performance measures that are most important to people who receive LTSS and their families
- Creation of a new payment system (aligning payment with quality) for NFs and certain HCBS based on performance on those measures
- Robert Wood Johnson Foundation State Quality and Value Strategies grant
- Lipscomb University contracted by Princeton University to provide technical assistance and facilitate QuILTSS stakeholder processes

Quality Improvement in Long-Term Services and Supports (QuILTSS)

Process Included:

- Survey of Federal & State Landscape
- Literature Review
- Key Informant Interviews with Other States
- Stakeholder Input Processes
- Data Analysis
- Comprehensive report and recommendations on Process and Quality Measure Domains
- Facilitation of ongoing stakeholder processes to develop and implement Quality Framework and payment approach

Quality Improvement in Long-Term Services and Supports (QuILTSS)

- 18 community forums in 9 cities (over 1,200 participants)
- Online survey process to gather input from consumers, families and providers
- One-on-one meetings with key stakeholders
- Feedback, along with information gathered from other states, compiled by Lipscomb into a Technical Assistance Report, available at <http://www.lipscomb.edu/transforming/tareport>

**Technical Assistance Report to
Bureau of TennCare on the
Quality Improvement In Long Term
Services and Supports (QuILTSS) Initiative**

From TA Report to Quality Framework

- Leveraged TA report with stakeholders
 - Brought the voice of consumers into discussions
- Twelve weeks of stakeholder meetings, facilitated by Lipscomb
 - Homework assignments, shuttle diplomacy
- End of three month period yielded agreement on a Quality Framework
- Intend to apply across LTSS and settings, where appropriate
 - Some measures will be different for HCBS

QuILTSS Quality Framework

- **Threshold Measures**

- Minimum standards to participate in QuILTSS

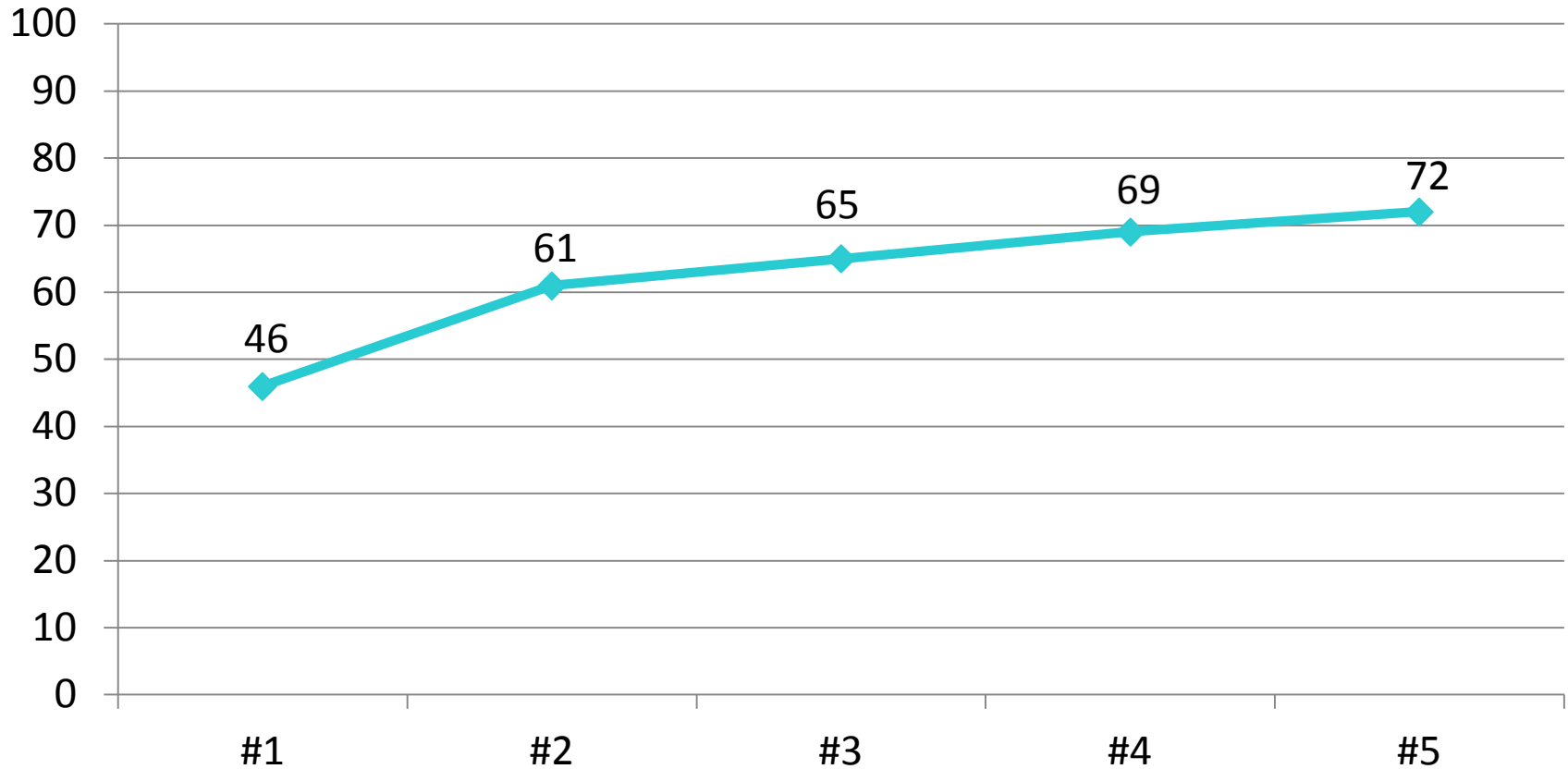
- **Quality Measures**

- **Satisfaction** 35 points
 - Member (15 points)
 - Family (10 points)
 - Staff (10 points)
 - **Culture Change/Quality of Life** 30 Points
 - Respectful treatment, member choice, member/family input, meaningful activities
 - **Staffing/Staff Competency** 25 Points
 - Staffing ratios, retention, consistent assignment, initial and ongoing staff training
 - **Clinical Performance** 10 Points
 - Health related measures, prevention and early detection, ongoing functional assessment
 - **Bonus Points** for significant quality improvement initiatives

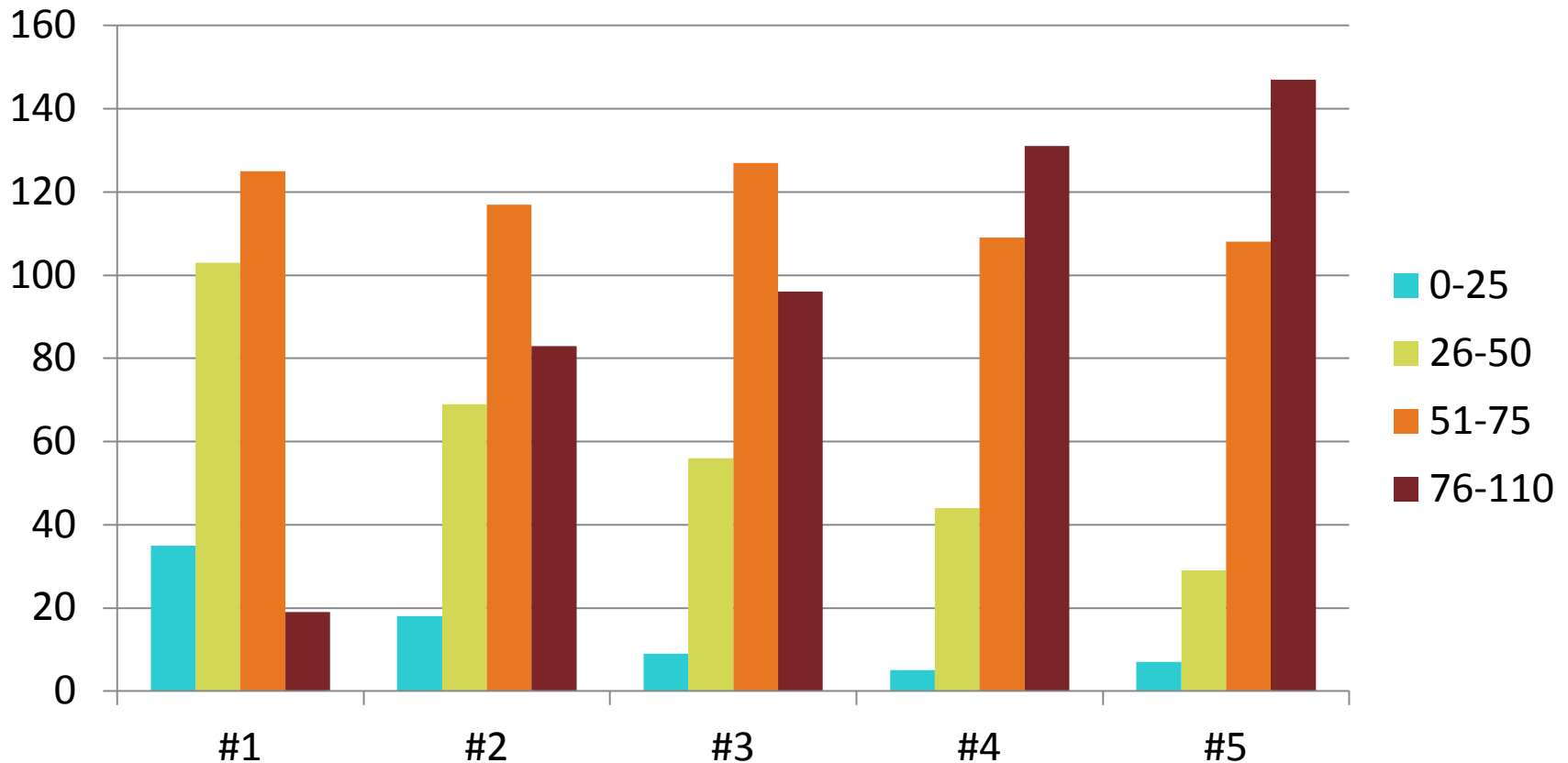
Implementing QuILTSS

- NFs have completed 5 quarterly submissions
- 291 NFs have made quality submissions (296 Medicaid)
- Each NF submission is reviewed at least twice, often 3 times
- NFs are provided with a summary score sheet that outlines where points were earned and provides explanation for why points were not earned
- NFs have the opportunity to request reconsideration of individual items
- TennCare has a Reconsideration Committee of external stakeholders that reviews denials of reconsideration requests
- TennCare provides feedback and guidance to the industry as each new submission period begins
- MCOs have distributed over \$18 million in payments for quality-based rate adjustments for the first 4 submissions

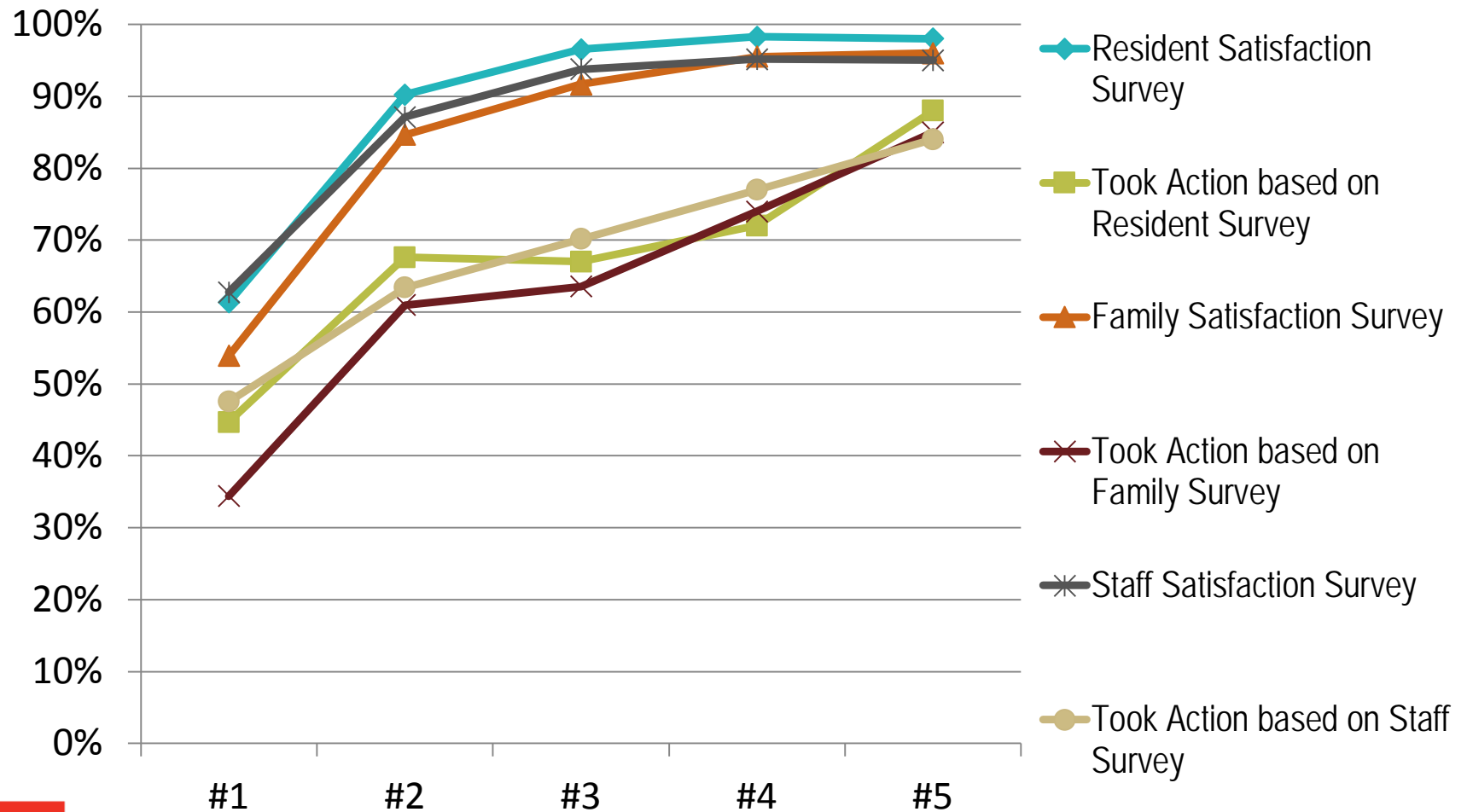
Total quality scores continue to improve (average total scores for all submitting NFs)



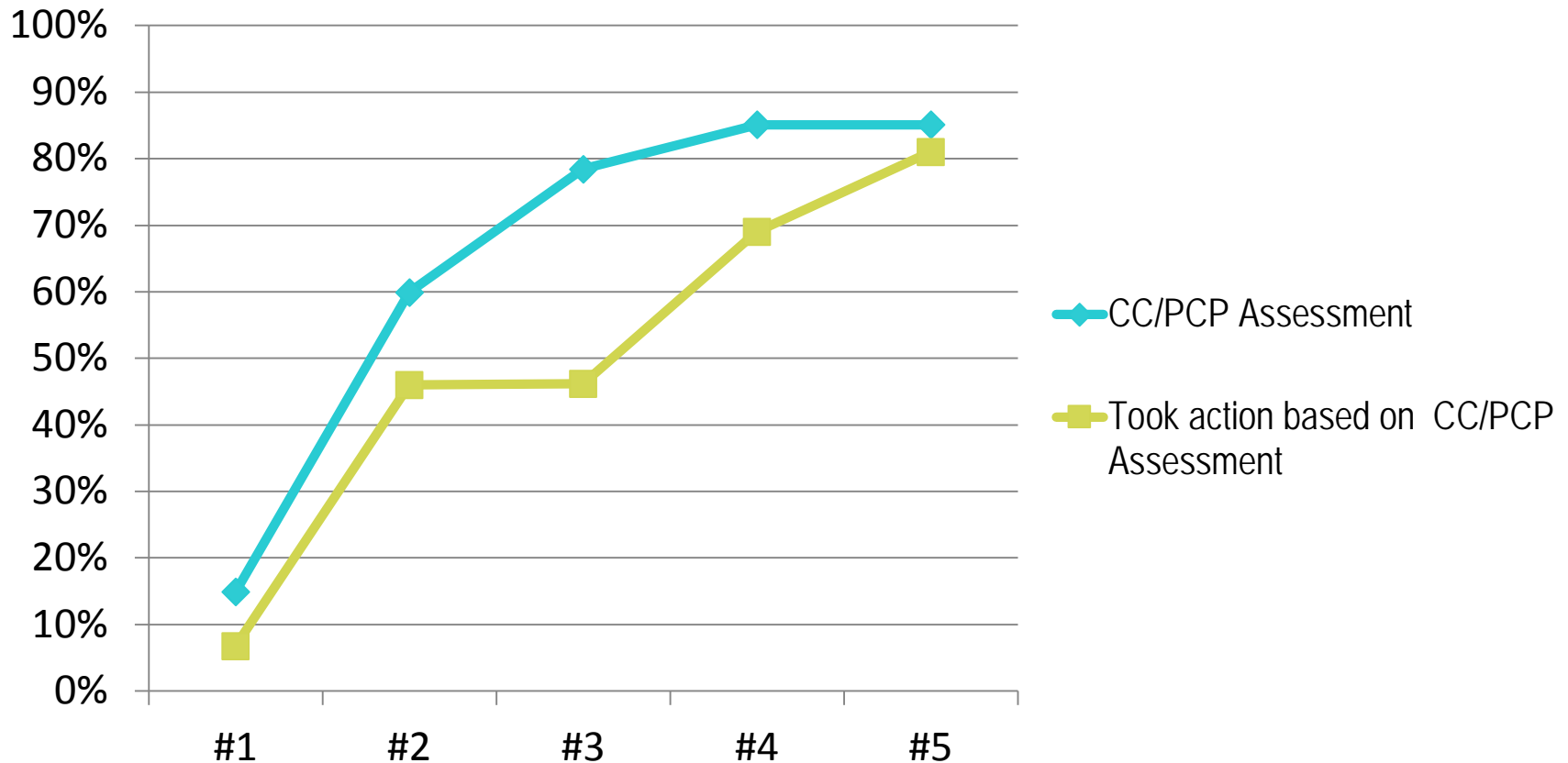
Number of NFs with higher quality scores continues to increase; number of NFs with lower quality scores declining



Significant improvement in conducting satisfaction surveys and taking actions to improve satisfaction

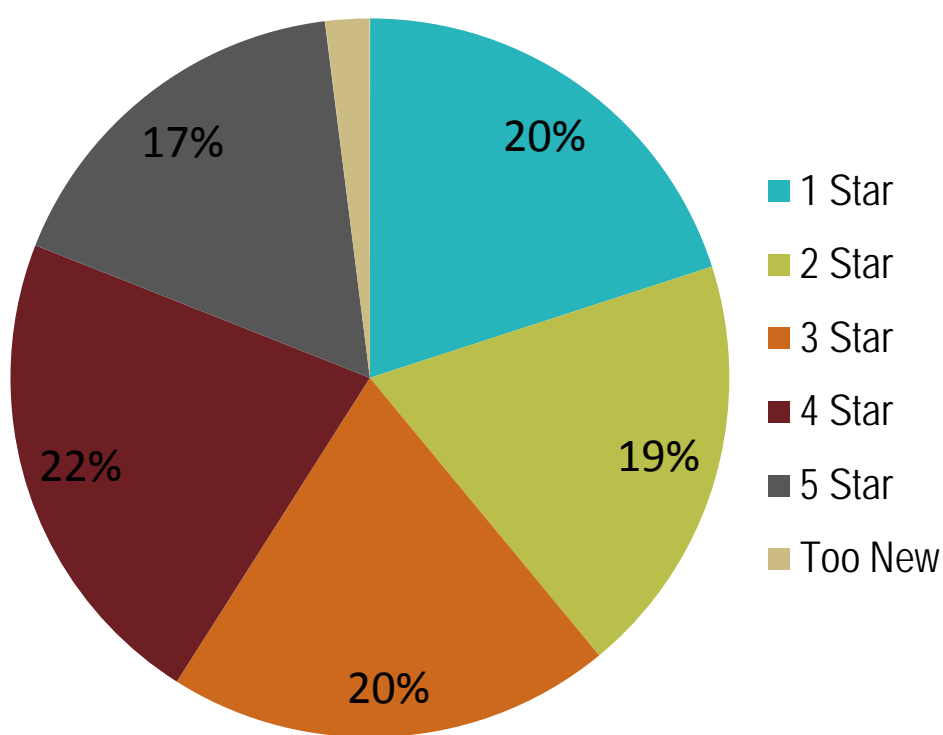


Facilities engaging in Culture Change/Person Centered Planning assessment and improvement

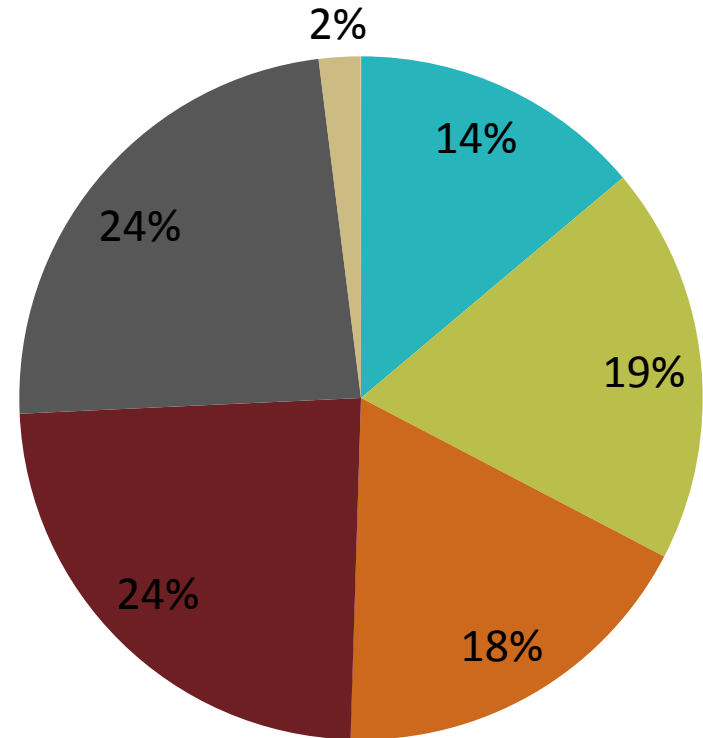


TN 5 Star rating is improving

October 2013, average=2.9



February 2015, average=3.2



Lessons Learned (so far)...

- Stakeholder involvement is key (formal and informal)
- Transparency is critical (nobody likes surprises)
- This is an iterative process (you cannot get there all at once)
- HCBS is more complicated/takes longer to get there
 - Person-Centered Plan is key to driving the member experience
- You will need to develop the capacity of the system to measure and improve quality
- Be at least two steps ahead of the system (you need a lot of lead time for the planning)
- Communication, communication, communication (and then communicate some more)
 - Frequent
 - Clear
 - Consistent
 - Questions
- Program must support member-focused quality
- Clear expectations and clear feedback to providers

Future of QuILTSS and Value-Based Purchasing in Tennessee

- Full Value-Based Purchasing model for NFs
 - Quality component of the per diem rate under new reimbursement methodology (rather than rate adjustment)
 - Focus on quality *performance* instead of quality improvement *activities*
- HCBS QuILTSS
- New Behavioral Health Crisis Prevention, Intervention and Stabilization services and Model of Support to be implemented later this year
 - Delivered under managed care program, in collaboration with I/DD agency
 - Focus on crisis prevention and in-home stabilization, sustained community living, reduced inpatient utilization
 - Performance measures (e.g., decrease in PRN use of anti-psychotics, decrease in crisis events, increase in in-place stabilization when crises occur, and decrease in inpatient psychiatric admissions and inpatient days) will be tracked and utilized to establish a VBP component (incentive or shared savings) for the reimbursement structure

Future of QuILTSS and Value-Based Purchasing in Tennessee

- Employment and Community First (ECF) CHOICES
 - MLTSS program to be implemented in 2016
 - Promotes integrated employment and community living as the first and preferred outcome for individuals with I/DD
 - Outcome-based reimbursement for certain employment services
 - Reimbursement approach for other services will take into account provider's performance on key outcomes, including number of persons employed in integrated settings and # of hours of employment (after a reasonable period for data collection and benchmarking)

Future of QuILTSS and Value-Based Purchasing in Tennessee

- “QuILTSS” for MCOs – quality withhold/report card
 - *“Members get services; providers get paid.”*
 - Timely initiation of services
 - Gaps in care (late/missed visits)
 - Timely claims payment
 - Claims payment accuracy
 - Satisfaction
 - Member/Family/Staff
 - Culture Change/Quality of Life
 - Respectful treatment, member choice, member/family input. meaningful activities
 - Employment, community integration
 - Staffing/Staff Competency
 - Care Coordinator ratios, retention, consistent assignment, training
 - Clinical Performance
 - HEDIS

Future of QuILTSS and Value-Based Purchasing in Tennessee

- Implementing “QuILTSS” for MCOs
 - Utilize existing audit processes
 - Timely initiation of services; claims payment timeliness and accuracy
 - Utilize existing (or enhance) reporting processes (with validation)
 - Care Coordinator ratios, retention, consistent assignment, training
 - Employment
 - Leverage technology
 - Electronic visit verification system measures gaps in care and point-of-service satisfaction survey
 - Satisfaction surveys
 - National Core Indicators-AD (for members)
 - Standardized web-based provider satisfaction survey (EQRO?)
 - Culture Change/Quality of Life
 - NCI-AD
 - Clinical Performance
 - HEDIS



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THANK YOU

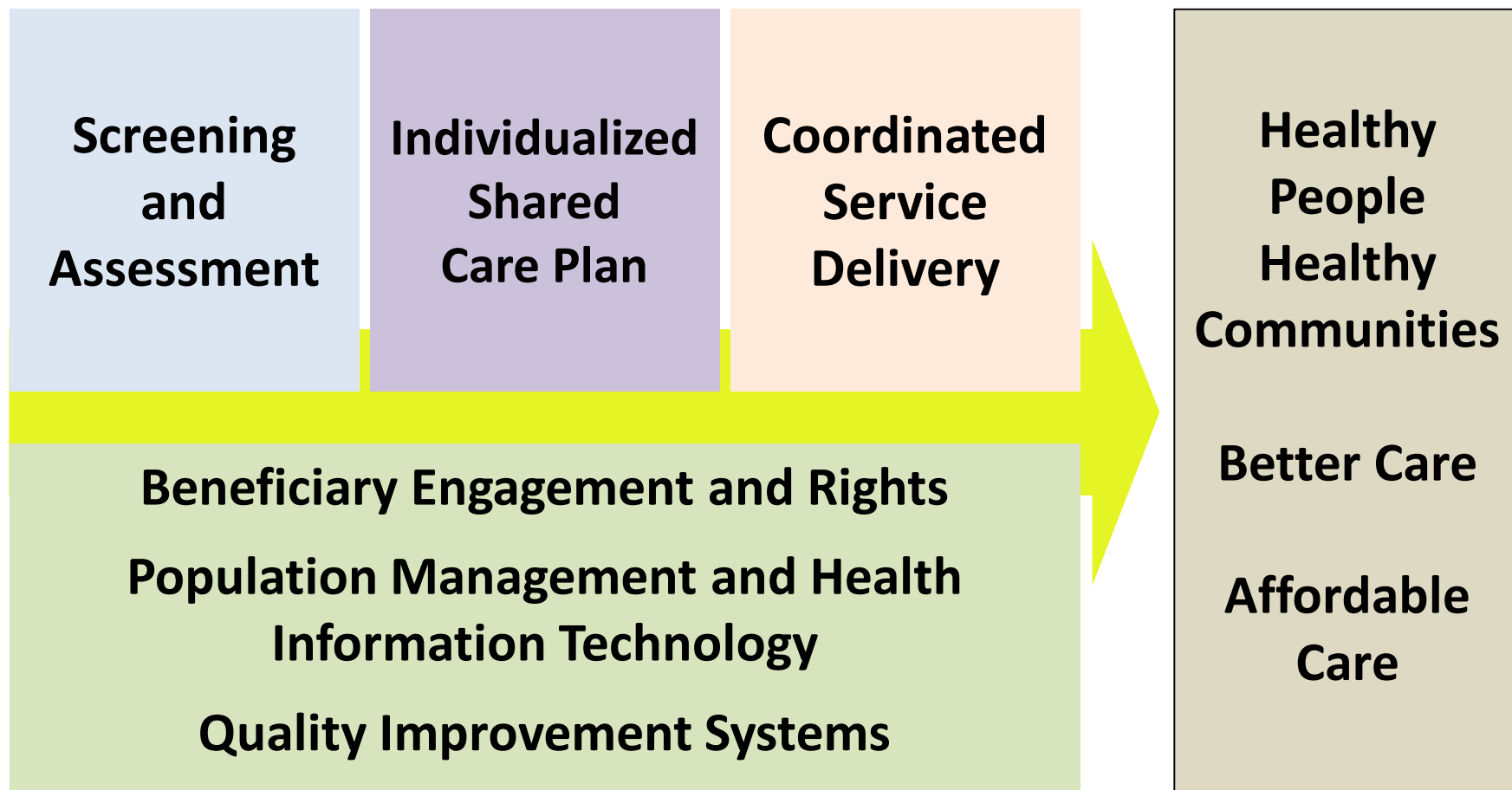


Improving Outcomes for People with Complex Needs

Erin Giovannetti, Jessica Briefer French, Erica Anderson, Maureen Henry, Sarah Hudson Scholle



Model for Evaluating Quality



Case Studies on Integrated Care

Project Aims:

1. Understand integration practices
2. Describe care plan goals
3. Assess concordance between care plans and what individuals say matters most
4. Evaluate use of Patient Reported Outcome Measures for goal setting, measurement and care planning

Case Study Methods

- **Target Organizations**
 - Integrated medical and long-term services and supports (LTSS) or behavioral healthcare
- **Target Populations**
 - Frail older adults
 - Individuals with disabilities
 - People with severe mental illness
 - People with dually eligibility
- **Data Collection**
 - 2 sets of site visits
 - Interviews, observation, care plan review

“Integrated Care” is a misnomer

- **Care continues to be delivered in silos**
 - Medical
 - Behavioral
 - Supportive services
- **Information sharing impeded and idiosyncratic**
 - Language and culture of different disciplines
 - Technology
 - Communication depends on case manager

What is a Care Plan?

In theory

- Person-centered
- Goal-based
- Interdisciplinary, shared
- Comprehensive
- Living
- Quality of life goals

More often in reality

- Service centered
- Problem-based
- Focused on LTSS and care coordination
- Address medical, functional and social needs
- Sometimes standardized

Care Plan Goals

- Where documented, goals are substantially aligned with what people say is important
 - Rarely identical or discordant
- Care manager's words or summary
- Short term, service-focused, related to outcomes important to individual, but logical connection is not documented

Substantially Aligned Goals

Individual	Care Plan
<p>“The main one is to keep trying to get -- move, walk, and do some of the things I like to do”</p>	<ol style="list-style-type: none">1. Member will have a pain level of 4 or less, which will enable her to be more independent with her ADLs and IADLs.2. Member will lose 15 pounds over the next six months

Examples of Aligned Individual Goals

- *“Independent. Living independently.”*
- *“I’m trying to be able to walk and get my pain under control and manage it. That is my goal because I love walking.”*
- *“But now, I’m trying to move out into a senior citizen place, which I don’t have to worry about snow and leaves and glass and all of that...”*

Examples of Goals Missing from Care Plan

- *"One of the big activities that I want to do this, is to organize a fashion/talent show for young people in the shelter [text deleted]. And that's my goal for this summer, to do that."*
- *"I wanted to open a coffee shop. I mean, I worked a lot in coffee shops, so I have an idea how to already do some -- how to open a business and stuff like that."*
- *"I wanted to work at Walmart or something like that, but I told her if I could get my pain managed, which I know now I'm not being able to manage my pain and the doctor has tried several things."*

Goal Setting Approach

- **Effective goal setting**

- Create a trusted relationship
- Listen and be present
- Respect the individual

- **Variation observed**

- Individual as expert
- Nudging or pushing
- Who writes the goal/whose words are used
- Family involvement

- **Challenges**

- Unambitious goals
- Conflicts between individual and family goals
- Prioritization
- Disinterest in setting goals
- Unrealistic or overly ambitious goals (infrequent)

Person Reported Outcome Measures

- **Potentially helpful**
 - Prompt discussion of hidden concerns
 - Tracking individuals' progress toward goals
 - Assessing population wellbeing
- **May provide an added benefit when accompanied with a conversation to elicit goals**

Next Project

Drive transformation in care for people with complex needs through concurrent efforts

- Pilot standards for person-centered, integrated LTSS
- Develop and demonstrate person-driven outcome measures

Next Project: Goals

- **Pilot standards for person-centered, integrated LTSS**
 - Help CBOs and MCOs work together
 - Encourage coordination between LTSS and medical care
- **Develop and demonstrate person-driven outcome measures**
 - Care planning *and*
 - Performance measurement

Project Impact

- Drive transformation in care for people with complex needs, including LTSS
- Insight on how to use person-driven outcomes for this population
- Give individuals a stronger voice in goals of care, measurement of care quality
- Address policy need for patient-centered LTSS quality measures

Moving Towards Quality Measures that Enable us to...

Manage *care* to individual outcomes

and

Measure *performance* against a common
yardstick



Care Coordination in MLTSS

2015 NASUAD HCBS Conference, Washington, D.C.
August 31, 2015

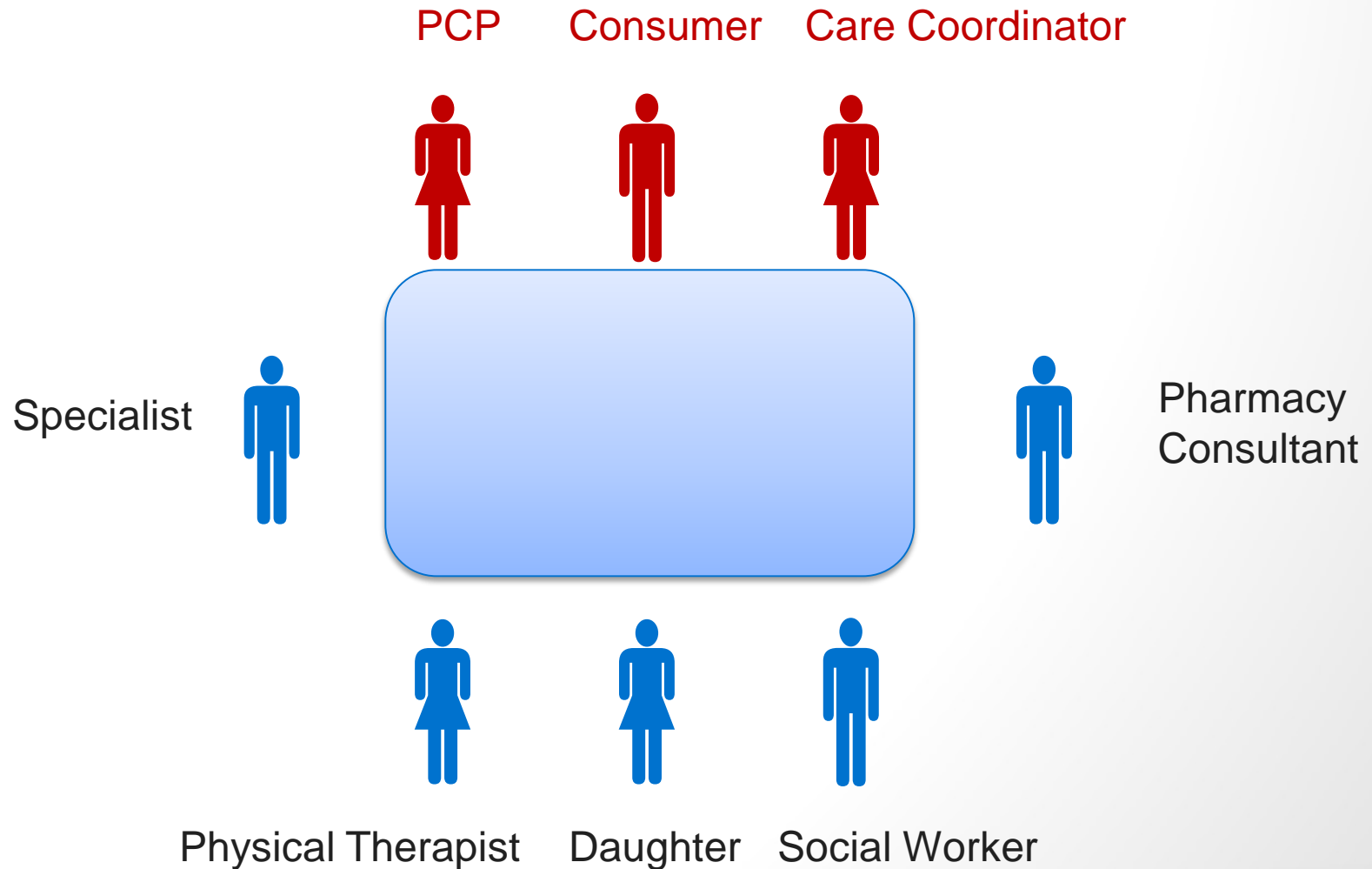
Paul Saucier, Truven Health Analytics

“In theory there is no difference between theory and practice.

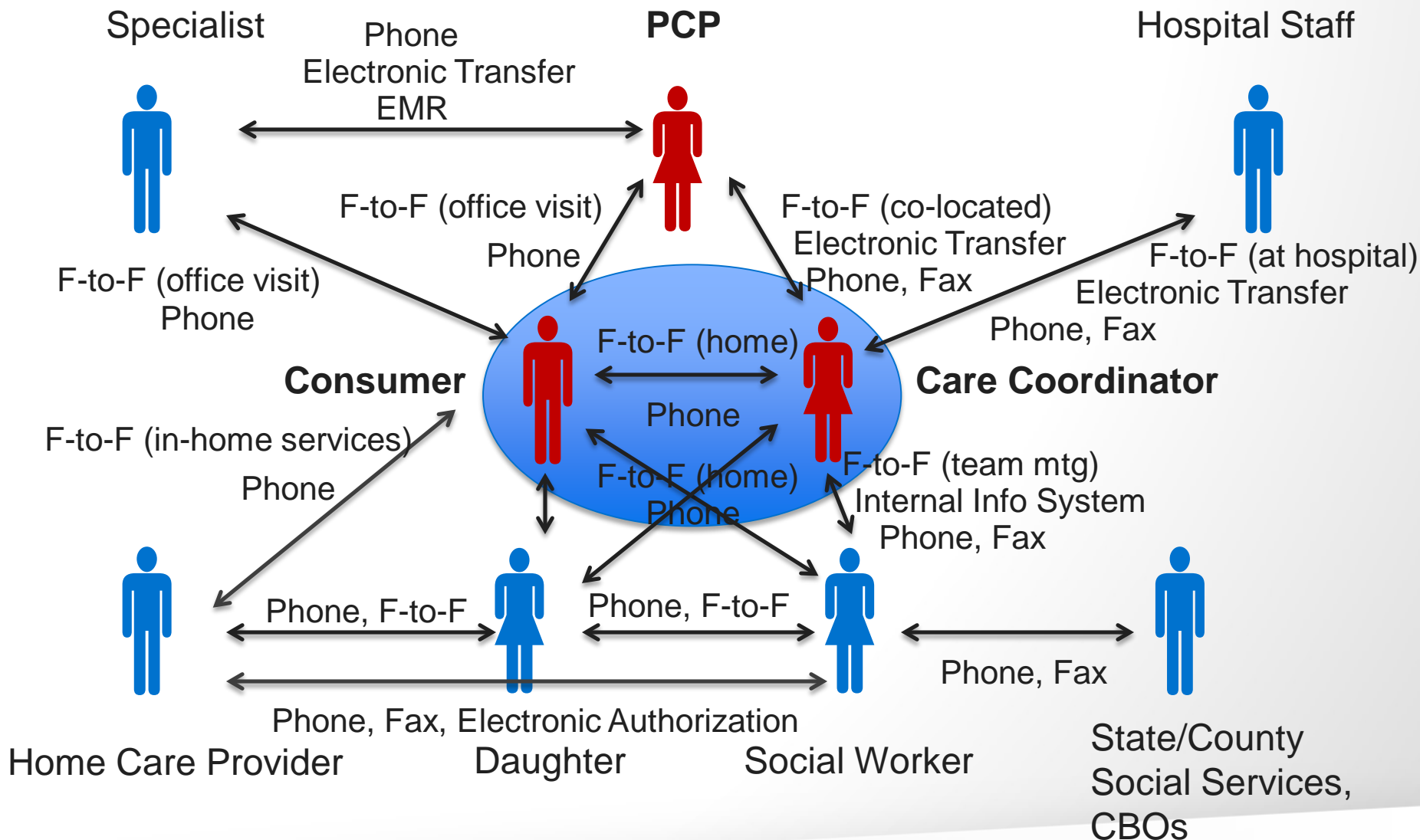
In practice there is.”

Yogi Berra

Integrated Care Planning and Coordination– Theory



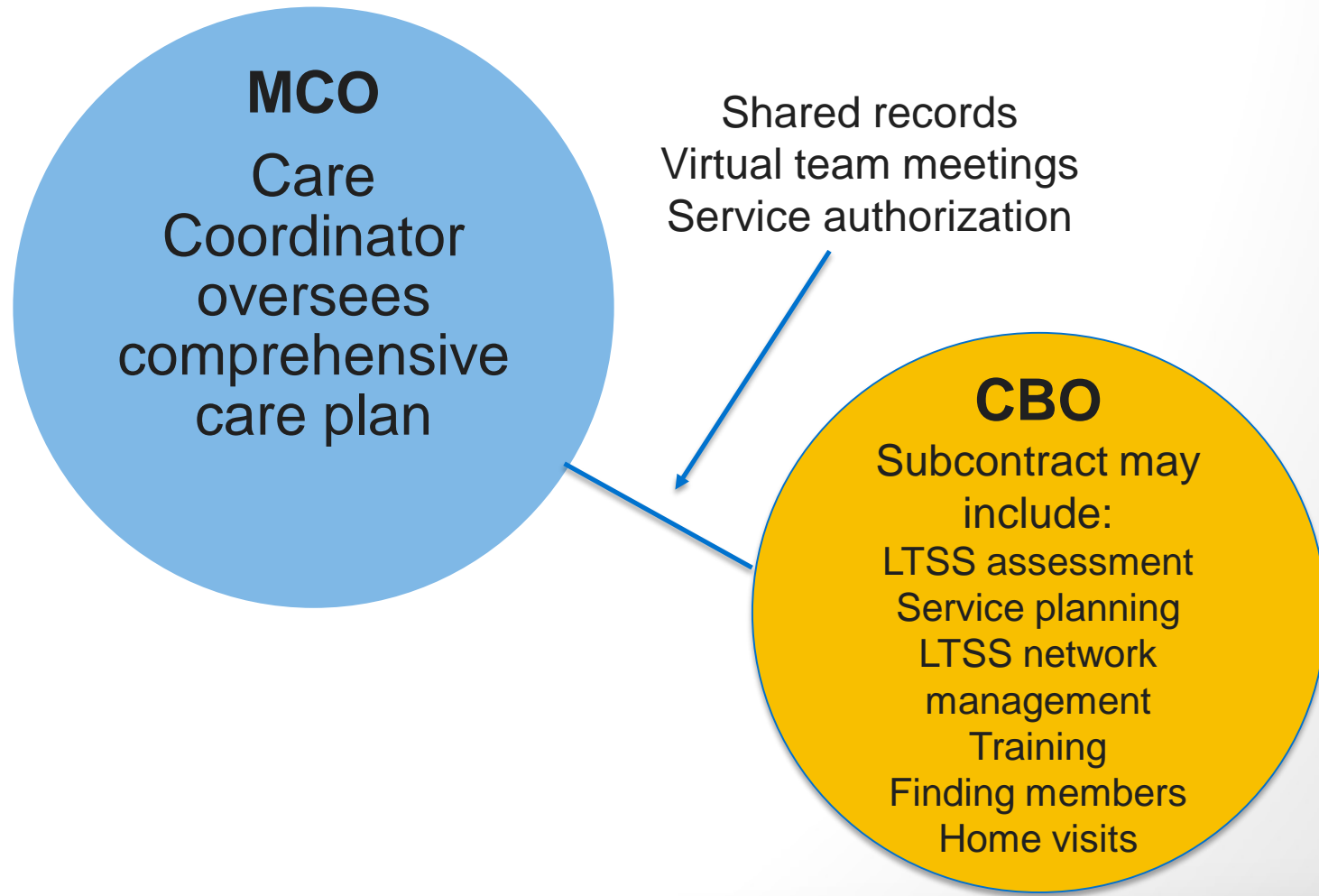
Integrated Care Planning and Coordination– Practice



Care Coordinator Role is Key

- Assesses the consumer's needs and preferences
- Works with PCP and multiple other parties to plan, authorize and coordinate services
- Monitors care plan
- Follows consumer across settings and through transitions of care
- Uses multiple methods to facilitate information transfer across multiple parties

Shared Functions Care Coordination Model Emerging in MLTSS



Integrated Care Remains a Work in Progress

- Working out roles and protocols in shared functions models
- Determining who needs care coordination, and at what intensity
- Developing HIT in LTSS agencies
- Improving interoperability across systems
- Identifying standards that can be applied across models

“The secret of getting ahead is getting started.”

Mark Twain

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MLTSS Innovations in Service Delivery to Individuals with Intellectual and Developmental Disabilities

National Association of States United for Aging and Disabilities
HCBS Conference
2015



The Service Delivery System for Individuals with I/DD in Tennessee

- Entire Medicaid population, including individuals with I/DD enrolled in managed care since 1994
- ICF/IID services and three Section 1915(c) ID waivers carved out
- 70% of individuals with I/DD receiving LTSS are dual eligible
- Significant opportunities to improve coordination of physical/behavioral health/LTSS needs

The Service Delivery System for Individuals with I/DD in Tennessee

- Total TennCare LTSS budget roughly \$2.1 billion
 - \$1.2 billion serves 30,300 people in CHOICES (HCBS and NF)
 - \$936 million serves 8,800 in HCBS waivers and ICFs/IID
- 3% of TennCare members (roughly 38,400 of 1.2 million) account for 50% of program costs
- Of that 3%, nearly 7,000 are people with ID receiving LTSS
- More than 75% of all people with ID receiving LTSS are in the top 3% of the most expensive people served in TennCare (consuming 50% of program expenditures)



The Service Delivery System for Individuals with I/DD in Tennessee

- Longstanding federal litigation regarding large state institutions
 - Arlington Developmental Center closed in 2010
 - *U.S. v. State of TN* (Arlington case) ended in 2013
 - Clover Bottom Developmental Center to close in 2015
 - Exit Plan to end *U.S. v. State of TN* (Clover Bottom case) approved in 2015, including:
 - Closure of Greene Valley Developmental Center in 2016 (last large state institution)
 - *Opportunities* to implement improvements in health care

Improving the Service Delivery System for Individuals with I/DD in Tennessee

- **Psychotropic Medications**
 - Training for prescribers, individuals and families on the appropriate use of psychotropic medications
 - Changes in pharmacy prior authorization criteria for psychotropic medications for individuals with I/DD
 - Regional psychopharmacology review teams/process
- **Behavior Services**
 - New behavioral health crisis prevention, intervention, and stabilization services
 - Focus on crisis prevention and in-home stabilization, sustained community living, reduced inpatient utilization
 - Expanded capacity for therapeutic behavioral respite services

Improving the Service Delivery System for Individuals with I/DD in Tennessee

- *Employment and Community First CHOICES*
 - New MLTSS program component to be implemented in 2016
 - Integrates physical and behavioral health and LTSS for individuals with I/DD
 - Promotes integrated employment and community living as the first and preferred outcome for individuals with I/DD
 - Outcome-based reimbursement for certain employment services
 - Reimbursement approach for other services will take into account provider's performance on key outcomes, including number of persons employed in integrated settings and # of hours of employment (after a reasonable period for data collection and benchmarking)

The IDD Toolkit

Training for prescribers, individuals and families
on the appropriate use of
psychotropic medications



Barriers to Appropriate Health Care for Adults with IDD

- Physicians and nurses may have little or no experience treating adults with IDD
- They may have concerns about reimbursement rates
- Due to lack of knowledge they may feel inadequate, feel anxious
- Physical accessibility of the office may be an issue
- Communication may be more difficult
- Physical examinations may be difficult
- Tests (e.g., blood draw, x-rays, MRIs) may be difficult

Additional Barriers to Appropriate Care

- Adults with IDD may have complex, difficult-to-treat or little known medical conditions
- Lack of trained community health care providers may force people to emergency departments for care
- Lack of trained mental health providers often results in the overuse of psychotropic medications and polypharmacy
- Psychotropic medications are often used to treat “challenging behavior” despite little evidence of effectiveness

1906-1996



Development of Clinical Practice Guidelines and Tools for Primary Care



Development of Clinical Practice Guidelines and Tools for Primary Care



Closed
March 2009



DD Primary Care Initiative

Canadian Consensus Guidelines for the Primary Care of Adults with Developmental Disabilities

- Developed: Colloquium, Toronto (November 7 – 11, 2005)
- Published: *Canadian Family Physician* (November 2006)
- Updated: *Canadian Family Physician* (May 2011)

DD Primary Care Initiative

Canadian Consensus Guidelines for the Primary Care of Adults with DD (2011)

31 guidelines, 74 evidence-ranked recommendations:

- General issues (9)
- Physical health issues (12)
- Behavioral and mental health issues (10)

Primary care of adults with developmental disabilities

Canadian consensus guidelines

William F. Sullivan MD CCFP PhD Joseph M. Berg MB BCh MSc FRCPsych FCCMG Elspeth Bradley PhD MBBS FRCPC FRCPsych
Tom Cheetham MD CCFP Richard Denton MD CCFP FCFP FRMMS John Heng MA Brian Hennen MA MD CCFP
David Joyce MD CCFP Maureen Kelly RN MPA Marika Korossy Yona Lunskey PhD CPsych Shirley McMillan RN MN CDDN

Abstract

Objective To update the 2006 Canadian guidelines for primary care of adults with developmental disabilities (DD) and to make practical recommendations based on current knowledge to address the particular health issues of adults with DD.

Quality of evidence Knowledgeable health care providers participating in a colloquium and a subsequent working group discussed and agreed on revisions to the 2006 guidelines based on a comprehensive review of publications, feedback gained from users of the guidelines, and personal clinical experiences. Most of the available evidence in this area of care is from expert opinion or published consensus statements (level III).

Main message Adults with DD have complex health issues. Primary care identifies the particular health issues faced by adults with DD to improve their quality of life, to improve their access to care, and to prevent suffering, morbidity, and premature death. These guidelines synthesize general, physical, behavioural, and mental health issues of adults with DD that primary care providers should be aware of, and they present recommendations for prevention and management based on current knowledge that primary care providers can apply. Because of interacting biologic, psychosocial, and social factors that contribute to the health and well-being of adults with DD, these guidelines emphasize involving caregivers, adapting procedures when appropriate, and seeking input from a range of health professionals when available. Ethical care is also emphasized. The guidelines are formulated within an ethical framework that pays attention to issues such as informed consent and the assessment of health benefits in relation to risks of harm.

Conclusion Implementation of the guidelines proposed here would improve the health of adults with DD and would minimize disparities in health and health care between adults with DD and those in the general population.

Résumé

Objectif Mettre à jour les lignes directrices canadiennes de 2006 sur les soins primaires aux adultes ayant une déficience développementale (DD) et présenter des recommandations pratiques fondées sur les connaissances actuelles pour traiter des problèmes de santé particuliers chez des adultes ayant une DD.

Qualité des preuves Des professionnels de la santé expérimentés participant à un colloque et un groupe de travail subséquent ont discuté et convenu des révisions aux lignes directrices de 2006 en se fondant sur une recherche documentaire exhaustive, la rétroaction obtenue des utilisateurs

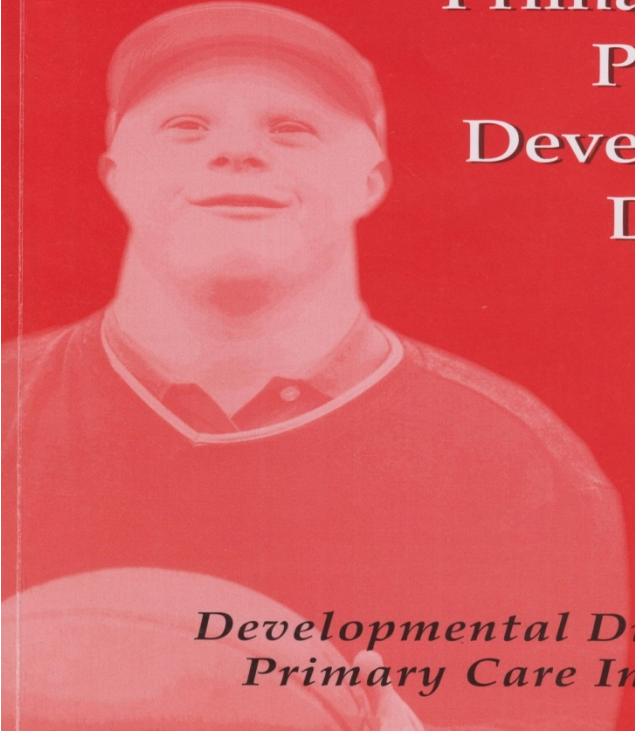
KEY POINTS As a group, adults with developmental disabilities (DD) have poorer health and greater difficulty accessing primary care than does the general population. They have different patterns of illness and complex interactions of comorbidities. The guidelines address the general, physical, behavioural, and mental health issues of adults with DD, and they emphasize conditions not screened for in routine health assessments of the general population. Ethical issues, such as informed consent and assessment of benefits in relation to risks, are addressed. Among the most important updates are consideration of atypical manifestations of pain and distress in adults with DD and a strong recommendation to avoid inappropriate long-term use of antipsychotic medications to address behavioural issues.

POINTS DE REPÈRE Collectivement, les adultes ayant des déficiences développementales (DD) sont en moins bonne santé et ont plus de difficultés à avoir accès aux soins primaires en comparaison de l'ensemble de la population. Les maladies évoluent différemment et présentent entre elles des interactions complexes chez ces personnes. Les lignes directrices font la mise en jour des recommandations pour la santé générale, physique, comportementale et mentale des adultes ayant une DD, en particulier pour les problèmes qui ne sont pas dépistés dans les évaluations systématiques de la santé dans la population en général. Elles traitent des questions d'ordre éthique, comme le consentement éclairé et l'évaluation des bienfaits par rapport aux risques. Parmi les mises à jour les plus importantes, on peut mentionner les manifestations atypiques de la douleur et de la détresse chez les adultes ayant une DD et une très forte recommandation d'éviter l'utilisation à long terme inappropriée des antipsychotiques pour les problèmes comportementaux.

This article has been peer reviewed.
Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician 2011;57:541-53

La traduction en français de cet article se trouve à www.cfp.ca dans la table des matières du numéro de mai 2011 à la page e154.

2 0 1 1 E D I T I O N



Tools for the Primary Care of People with Developmental Disabilities

*Developmental Disabilities
Primary Care Initiative*

IDD Health Care E-Toolkit

- The Vanderbilt Kennedy Center UCEDD and LEND, University of Tennessee Boling Center UCEDD and LEND, and the Tennessee Department of Intellectual and Developmental Disabilities were awarded a one-year Special Hope Foundation Grant in 2012, to develop an electronic Health Care Toolkit, an adaptation of Canadian Primary Care tools.

Efforts to Reduce Health Care Barriers

- Adapting the “Tools for the Primary Care of People with Developmental Disabilities” for the U.S.
 - Revising some significant language differences
 - Revising information about informed consent
 - Including information about the Americans with Disabilities Act and accessibility requirements
 - Creating an Autism Health Watch Table (although Canadian tools now include a more in-depth Autism Health Watch Table)

Efforts to Reduce Health Care Barriers

- Making the IDD Toolkit easily accessible on the Web and responsive on multiple devices
- Adding disability-related resources for Tennessee and the U.S.

HEALTH CARE FOR ADULTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Toolkit for Primary Care Providers

GENERAL ISSUES

- Communicating Effectively
- Informed Consent
- Informed Consent Checklist
- Office Organizational tips
- Today's Visit Form

PHYSICAL HEALTH ISSUES

- Cumulative Patient Profile
- Female Preventive Care Checklist
- Male Preventive Care Checklist

HEALTH WATCH TABLES

- Fragile X Syndrome
- Prader-Willi Syndrome
- Williams Syndrome
- 22q11.2 Deletion Syndrome

BEHAVIORAL AND MENTAL HEALTH ISSUES

- Initial Management of Behavioral Crises in Primary Care
- Risk Assessment Tool for Adults with IDD in Behavioral Crisis
- Behavioral Health Referral

These tools, except for Autism table, were developed by the Developmental Disabilities Primary Care Initiative (DDPCI) (2005-2014), Surrey Place Centre, Toronto, Canada, funded by Ontario Ministry of Community and Social Services and Ontario Ministry of Health and Long-Term Care, Surrey Place Centre, and Surrey Place Centre Charitable Foundation. The DDPCI published *Tools for the Primary Care of People with Developmental Disabilities to complement the Primary care of adults with developmental disabilities: Canadian consensus guidelines*. All tools © 2011 Surrey Place Centre. Adapted for use in the U.S. by the



www.iddtoolkit.org

Quick overview of the IDD Toolkit

- General Issues–Communication, Informed Consent, Office Organizational Tips
- Physical Health Issues–Preventive Care Checklists for Men & Women, Cumulative Patient Profile
- Health Watch Tables–Autism, Down syndrome, FASD, Fragile X, Prader–Willi, Williams syndrome, 22q11.2 deletion syndrome
- Behavioral and Mental Health Issues–Risk Assessment Tool, Behavioral Concerns Checklists, Psychiatric Symptoms Checklist, Psychotropic Medication Checklist

Tennessee's leadership sees the value of the IDD Toolkit

- Settlement in lawsuit seeking closure of Tennessee's remaining developmental center included a provision to train **prescribers** as well as **consumers, families** and **other caregivers** on the appropriate use of psychotropic medication, using the Toolkit.
- Research has found psychotropic medications are overprescribed and often inappropriately prescribed.
- Polypharmacy often occurs, which heightens the risk of drug side effects and drug interactions.
- Reducing use of psychotropic medications for “challenging behavior” is likely to result in more appropriate care and more cost-effective care.

Appropriate Use of Psychotropic Medications in Adults with IDD: Helping Individuals Get the Best Behavioral Health Care

- One version is specifically for prescribers—physicians, advanced practice nurses, physician assistants
 - Dr. Tom Cheetham serves as host
 - Language is medically oriented
 - FREE continuing medical education credits for completion (AAFP, AMA)
 - Included in new pharmacy PA criteria
- One version is specifically for consumers, family members, other caregivers, direct support staff and conservators
 - A parent serves as host
 - Language is more family-friendly

Appropriate Use of Psychotropic Medications in Adults with IDD: Helping Individuals Get the Best Behavioral Health Care

- **Goals:**
 - Improve prescriber education and practice
 - Promote appropriate behavior supports
 - Engage/equip the person with IDD and family/conservator in the health care partnership
 - Improve health and quality of life for individuals with IDD
 - Improve the member “experience”

For more information and to view training:

Please attend the session entitled

*Working Together to Improve Health Care
for Individuals with Intellectual and
Developmental Disabilities in Tennessee*

Tuesday, September 1, 4:00–5:15

Thank you!

Tom Cheetham MD, FAAIDD
Deputy Commissioner
for Health Services
Thomas.Cheetham@tn.gov

Janet Shouse
Program Coordinator
Janet.Shouse@vanderbilt.edu

Patti Killingsworth
Assistant Commissioner,
Chief of LTSS
Patti.Killingsworth@tn.gov

HCBS Conference MLTSS Intensive

Don Langer, CEO

UnitedHealthcare Community Plan of Texas



Importance of Employment

- Employment First – competitive and integrated employment preferred
- Essential component to meaningful community integration
- There is a compelling business case for employment of people with disabilities
 - 48% lower turnover rate than those who do not have disabilities,
 - have lower sick time use, and
 - perform equal to or better than nondisabled individuals 90% of the time

Key Trends

- The **Workforce Innovation and Opportunity Act (“WIOA”)**, effective July 1, 2015, requires all states to create a unified plan to align investment into workforce, education, economic development, vocational rehabilitation, Medicaid, and other human and social service delivery systems in support of a high-quality workforce development system that serves youth and adult job seekers with disabilities.
- Additional focus on employment has come from recent efforts associated with **Employment First (EF) policy**. EF prioritizes integrated employment and employment supports programs for persons with disabilities over separated employment or day-activity programs.
- **Employment benefits within managed care programs are becoming more common** in part due to recent CMS guidance on inclusion of employment within LTSS programs and due to the increased interest in managed care for Individuals with IDD.

Two Examples

Kansas

- 2013 Kansas moves to a fully integrated managed care contract inclusive of individuals with ID/DD – acute, bh, pharmacy
- 2014 ID/DD waiver services come under capitation as part of the fully integrated Medicaid managed care contract

Texas

- September 2014 - Texas Health and Human Services moved individuals with ID/DD into the Texas STAR+PLUS program for all acute benefits
- September 2014 - Texas Health and Human Services added employment and employment supports to the STAR+PLUS program
- 2014-2015 – Texas Stakeholder Groups working on Employment First and ID/DD System Redesign
- 2015 – Texas Developing ID/DD LTSS Pilot

So How Are We Responding?



Integrating Employment into Person Centered Planning Process

What we have done

- Trained our care coordinators in employment issues
- Provided Employment Specialists to support our care coordinators
- Mapped the system from the perspective of those we serve to identify opportunities for improvement
- Developed tools and resources for the individuals we serve to more easily navigate the system

What we have learned

- Employment is a new area for many of our care coordinators and additional support by someone who specializes in employment is critical
- Navigating between Voc Rehab and Medicaid remains challenging for many individuals but we continue to work to find ways to improve this process
- Concerns about loss of benefits remain a barrier to meaningful employment for many individuals

Building Networks & Relationships

What we have done

- Hired someone very knowledgeable about employment and vocational rehab
- Participated in stakeholder advisory committees to deepen our understanding of critical issues for individuals, families and providers
- Leveraged national partnerships and capacity to bring innovative approaches to the State

What we have learned

- Continual opportunity to build relationships and knowledge of managed care within the Voc Rehab community
- While many strategies are local and we need to have a State/Local lens, it is very helpful to be able to borrow from others who are doing well or have “solved” for a particular piece of the employment puzzle

Improving Community Capacity

What we do

- Survey the landscape
- Listen to individuals, families and other stakeholder to identify gaps and opportunities for improvement
- Evaluate our resources and capacity
- Find strategic partners that help us improve our community and outcomes for those we serve

What we have learned

- Relationships that come organically from this process of gap analysis provide the greatest benefit for those we serve and have the most lasting impact
- This approach ensures solutions are rooted in local communities while also borrowing best practices and lessons learned

Example: Project SEARCH

In 2014, UnitedHealthcare Sugarland Office became a host site for Project SEARCH.

We partnered with:

- Project SEARCH
- Fort Bend Independent School District
- Department of Assistive & Rehabilitative Services

Session on Wednesday, Sept 2 from 10-11:15 am to learn more



Project | SEARCH

Example: Empower Kansas

- Community investment grants focused on improving employment system and outcomes for individuals with disabilities.
- Funded three rounds of grants to a variety of organizations who were doing direct support to individuals in Kansas
- Empower Kansans also supports a grassroots coalition, the ***Employment Systems Change Coalition***, in developing a set of recommendations about employment supports and related policies in Kansas.
 - A cross disability group, including Kansans with disabilities
 - Constituent engagement activities (focus groups and listening sessions held across the state)
 - Research on current best practices in other states
 - Consultation and facilitation with National experts on employment of persons with Disabilities
 - The Kansas Council on Developmental Disabilities is also providing funding for some complementary efforts around employment system issues in Kansas and is a key partner in these activities.

Questions

Managed Long-Term Services and Supports (MLTSS) Site Visits

**Medicaid and CHIP Payment and Access
Commission**

Kristal Vardaman

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).

MACPAC Publications on LTSS

- June 2011 report on the evolution of managed care in Medicaid
- March 2012 report chapter on persons with disabilities
- March 2013 report chapter on dually eligible beneficiaries
- June 2014 report chapter on LTSS
- State policy compendia on nursing facility payment methods
- MACStats data figures on LTSS users

MLTSS Site Visits

In August and September 2014, MACPAC staff conducted five state site visits to states with MLTSS programs.

Our goals were to:

- educate staff on MLTSS
- identify policy questions for future inquiry
- inform the Commission's deliberations on the changing LTSS landscape

MLTSS Site Visits

- The states we visited were Arizona, Florida, Illinois, New York, and Wisconsin.
- States were chosen to include variation in implementation stage and program design, and for geographic diversity.

MLTSS Site Visits

- In each state, MACPAC and Mathematica staff met with a variety of stakeholders.
 - state Medicaid officials
 - plan representatives
 - provider association representatives
 - beneficiary advocates
- Following the site visits we identified key themes within each state and across states.

Site Visit Themes

Each MLTSS program is unique; states made different design choices in a number of areas:

- populations covered
- mandatory versus voluntary enrollment
- stand-alone MLTSS versus comprehensive Medicaid managed care plans
- geographic reach
- number and type of managed care organizations

Site Visit Themes

In states with recent transitions, preparation of the provider community was a major challenge.

- The provider community had to undergo a shift from one to several payers.
- States and plans employed a number of strategies to assist in the transition to new billing requirements.

Site Visit Themes

States implemented a number of transition protections, but service changes remained a source of dispute for advocates.

- Protections included requiring maintenance of services, providers, and payment levels for a set period of time.
- The mix of protections and the time during which they remain in place vary by state.

Site Visit Themes

The accuracy of provider directories was a source of frustration for beneficiary advocates.

- Arizona, Florida, and Wisconsin reported conducting ad-hoc “mystery shopper” calls to verify that providers are accepting new patients.
- Plan representatives reported that keeping this information up to date is a challenge for all plan types, not just MLTSS or Medicaid plans.

Site Visit Themes

States' performance measurement strategies varied, but states with longer MLTSS experience employed more financial penalties.

- States often work in collaborative manners with plans to address performance issues.
- Illinois was just beginning to use data to identify outliers and investigate patterns.
- Arizona and Florida described financial sanctions used for a variety of deficiencies.

Site Visit Themes

All states reported that strong partnerships with stakeholders are integral to a successful program.

- In New York, state Medicaid staff met monthly with plans and advocates, and convened councils and work groups on key issues.
- In Wisconsin, stakeholders described state Medicaid staff as accessible and collaborative.

Site Visit Themes

Stakeholders identified challenges that are likely to persist past implementation.

- Duplication of case management for stand-alone LTSS plans can cause communication challenges and confusion.
- Many stakeholders noted a need for better ways to assess plan quality.
- Transportation services were a concern across states.

Policy Questions

- How similar or dissimilar are level of care determinations across states?
- What are the advantages and disadvantages of having LTSS stand-alone plans versus integrated plans?
- What quality measures would improve oversight of MLTSS programs?
- How will HCBS and managed care regulations affect existing and future MLTSS programs?

Ongoing MACPAC Work

MLTSS issues integrated into our LTSS work:

- reviewing uniform assessment tools for eligibility and care planning
- monitoring HCBS quality measurement initiatives
- understanding assisted living payment and coverage policies
- determining how HCBS and managed care regulations may affect the breadth of options MLTSS programs provide



www.macpac.gov

@macpacgov

Medicaid Managed LTSS

Does it work?

Presentation at the National HCBS Conference
Washington DC

August 31, 2015

Debra J. Lipson, Senior Fellow, Mathematica

Overview

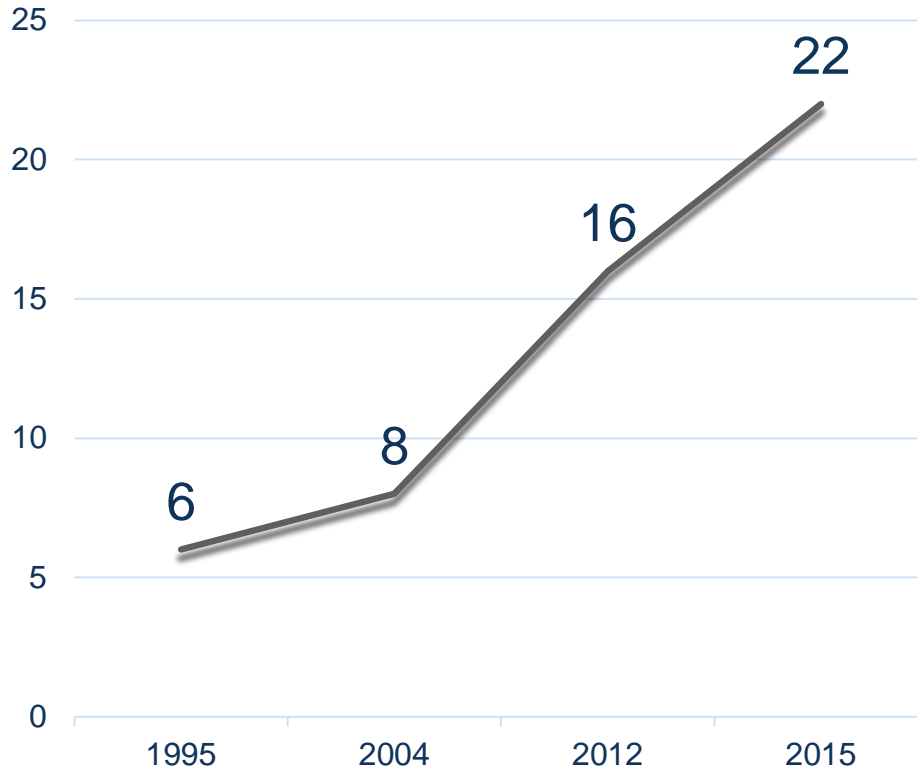
- What we know about MLTSS effectiveness
- What we don't know about MLTSS effectiveness
- Aims of the national MLTSS evaluation



What do we know about MLTSS and its Effectiveness?

Growth in Medicaid MLTSS

Number of States with MLTSS Programs



- **People enrolled in MLTSS programs increased:**

~ 800,000 in 2012

~ 1.2 million in 2015

Why are more states adopting MLTSS?

- **People with disabilities are among the highest cost Medicaid enrollees**
- **Conventional benefits of Medicaid managed care**
 - Ability to hold an entity accountable for outcomes (access, quality and costs)
 - Budget predictability – per capita rates set in advance
- **Plus potential for improved LTSS outcomes**
 - Improved quality of care and quality of life
 - Shift the balance from institutional care to HCBS
 - Better care coordination – across providers and across care settings: acute, primary and specialty care, LTSS, sometimes behavioral services

State Studies

- **Health care utilization**

- **Massachusetts (2009):** MLTSS program reduced risk of entering a NF by 32% over first two years of operation
- **Minnesota (2004):** Program enrollees had significantly fewer hospital days and preventable hospital admissions than the control group
- **Wisconsin (2005):** Primary care visits were 5.6% more frequent among MCO members than in a comparison group

- **Rebalancing**

- **Tennessee (2013):** share of LTSS population using HCBS rose from 17% before program implementation to 30% after first year of the program

State Studies

- **Access to HCBS & Care Coordination**

- **New York (2011):** Majority of enrollees said providers and services are always or usually on time and reported high satisfaction for quality and timeliness for visiting nurses and home health aides
- **Minnesota (2013):** Share of dual enrollees receiving HCBS increased from 9.5% before the program to nearly 40% after implementation
- **Texas (2011):** 74% of members reported usually or always getting care quickly, compared to the national Medicaid average of 80%
- **Arizona (2008):** 90% of enrollees say case managers provided help quickly and 93% say they responded promptly to a request for information

State Studies

- **Quality of Care**

- **Massachusetts (2011):** In 2009, one MCO scored in the 90th percentile or above in HEDIS measures for comprehensive diabetes care, monitoring patients on long term medications, and access to preventive services
- **New York (2012):** 90% of enrollees' reported functional ability that was stable or improved over a 6-12 month period; 80% of enrollees were stable or showed improvement in managing oral medication during the follow up period

State Studies

- **Cost savings/cost control**

- **Arizona (1996):** ALTCS saved an estimated 35% of projected nursing home costs
- **Massachusetts (2011):** Monthly medical costs for disabled MLTSS members in 2008 were \$3,600 versus \$5,210 for FFS beneficiaries
- **New York (2011):** From 2003 to 2010, annual per capita costs for MLTSS enrollees rose by 2.4% vs. 40% for FFS beneficiaries and 18% for nursing home spending
- **Texas (2009):** Combined savings in first 2 years of the program were about \$6 million (\$4 per member per month)
- **Wisconsin (2005):** Average individual monthly costs for a sample of participants were \$452 lower than the comparison group

What we don't know about MLTSS effectiveness

So it works, right?

- Overall positive findings

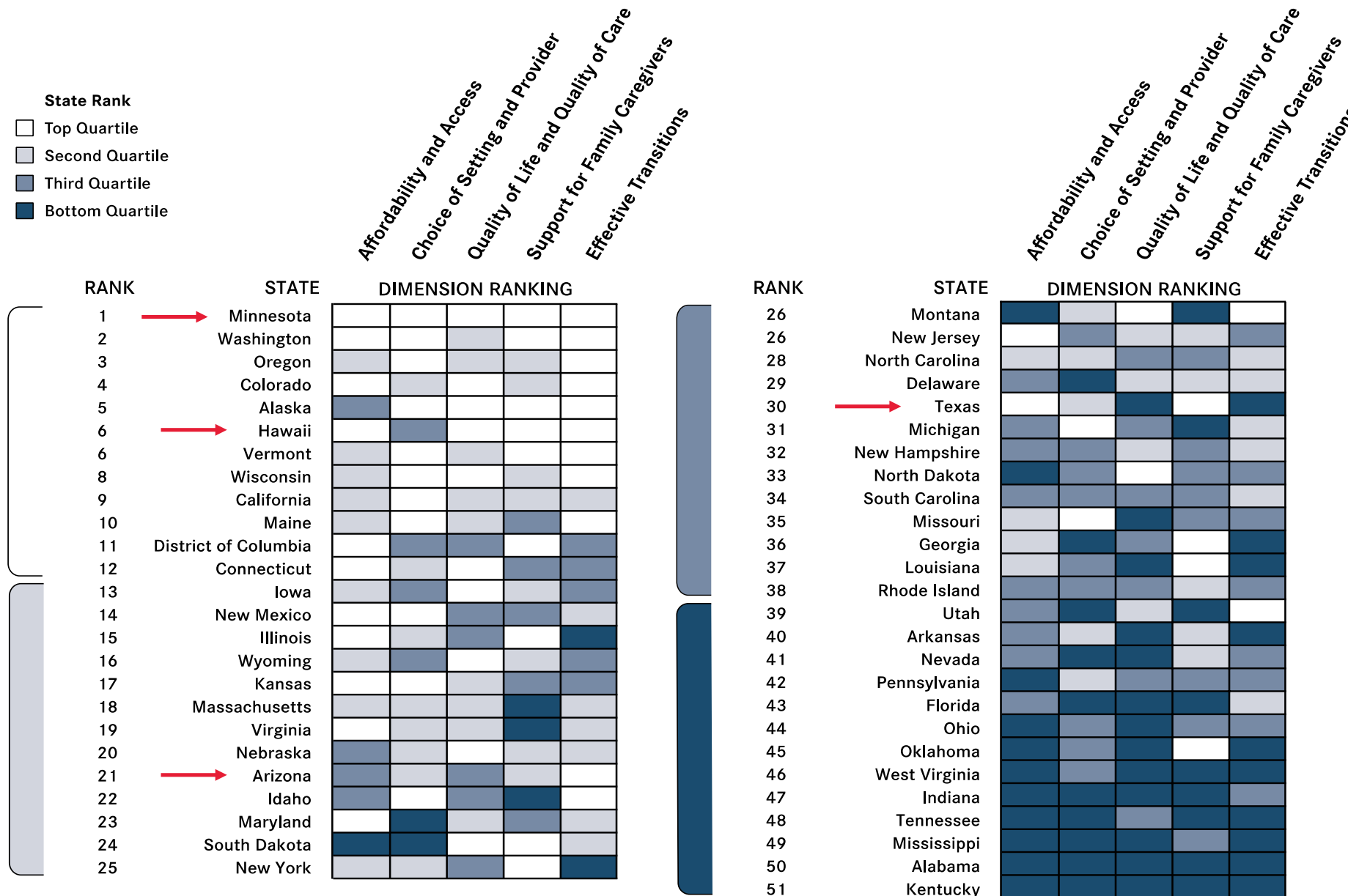
THINK  **AGAIN!**

- But it depends
 - What worked in 2000 or 2005 may not work in 2015
 - What worked in one state may not work in another
 - What worked for one population group may not work for another
 - What works in states with extensive managed care contracting experience may not work in one without it

Current evidence on MLTSS

- **Few of the recent studies on second generation programs use valid comparison groups; more common in early studies of first generation programs**
- **State trends do not control for other factors affecting outcomes**
- **Findings in one state do not necessarily apply to other states due to differences in:**
 - Enrolled populations; mandatory/voluntary enrollment
 - Covered services and degree of Medicare integration
 - MCO experience with LTSS and MCO selection criteria
 - Capitation rate setting
- **Effects are influenced by state oversight**

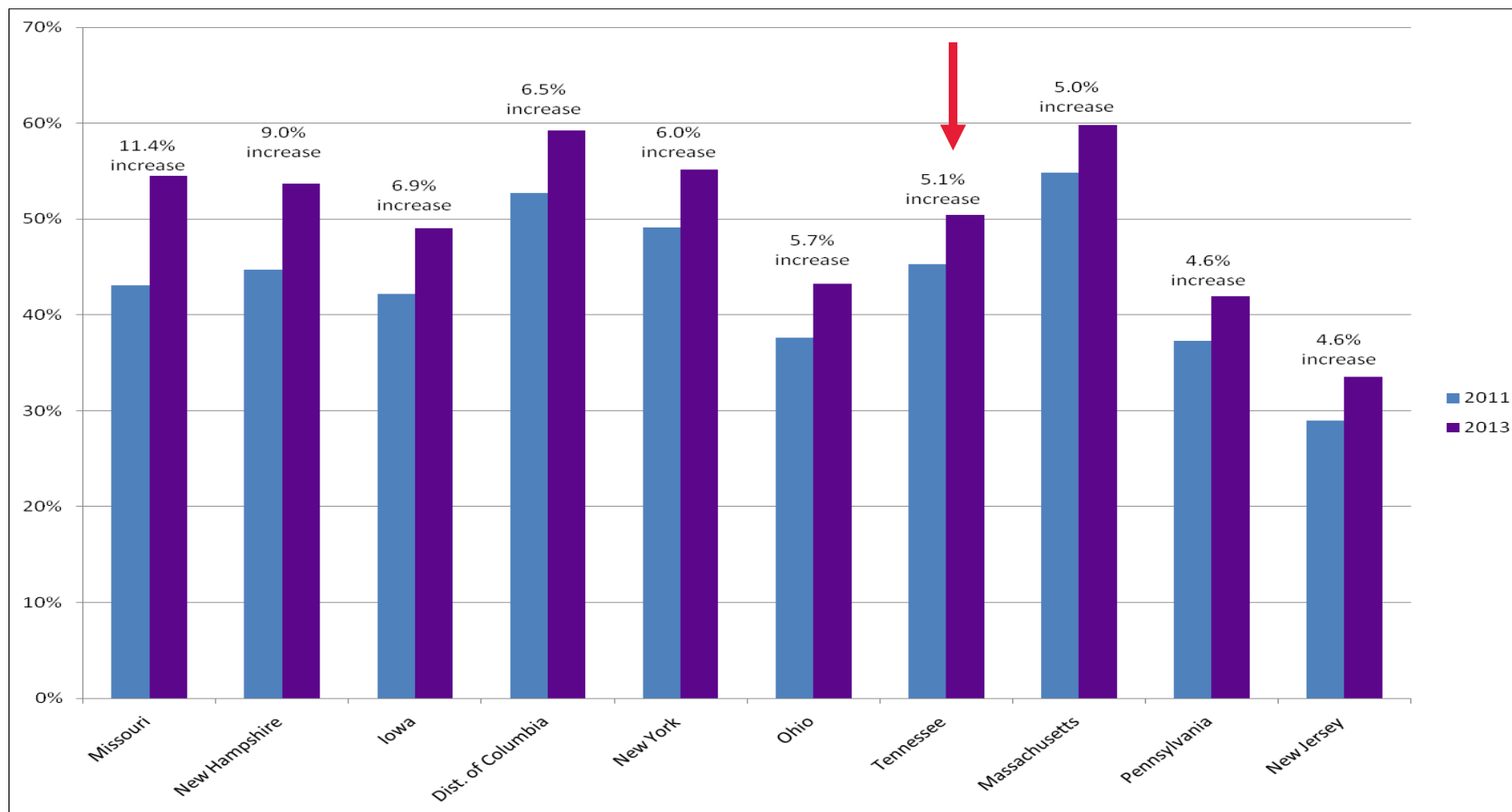
State Scorecard Summary of LTSS System Performance Across Dimensions



Note: Rankings are not entirely comparable to the 2011 Scorecard rankings in Exhibit A2. Changes in rank may not reflect changes in performance, and should not be interpreted as such.

Source: State Long-Term Services and Supports Scorecard, 2014.

States with the Greatest Increase in Medicaid HCBS Expenditures as a Percentage of Total Medicaid LTSS Expenditures, FY 2011-2013



Source: Truven Health Analytics, June 2015. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013

What we need to know

- **Elderly and people with disabilities are among the most vulnerable Medicaid beneficiaries**
 - Need more services and a wider range of benefits than other Medicaid enrollees
 - Greater potential for managed care financial incentives to result in under-service
 - Do MLTSS enrollees have adequate access?
- **In the past, most MLTSS programs were small or subject to oversight by federal Medicare officials as well as state Medicaid agencies**
 - Now, more people are enrolled in programs overseen largely by state Medicaid agencies – how are they performing?

What we need to know

- **How does MLTSS generally perform relative to FFS on key outcomes?**
 - LTSS rebalancing
 - LTSS and total Medicaid costs
 - Access and care coordination
 - Quality of care and quality of life
- **What accounts for differences in effectiveness between MLTSS and FFS?**
 - Starting point of LTSS system?
 - State contracting and oversight?
 - MCO experience?

What we need to know

- **How does MLTSS program design affect outcomes? How do MLTSS programs with different designs and features compare to each other?**
 - Different methods used to set capitation rates
 - Different models for integrating (or not) with Medicare
 - How do provider and consumer protections affect LTSS utilization rates and continuity of care for beneficiaries?
- **Which characteristics of MLTSS programs are associated with better access, more balanced systems, and better quality of care? What are best practices?**

Major Research Questions in the National MLTSS Evaluation

State-Level Impact of MLTSS Programs

- **Does MLTSS produce more balanced state LTSS systems than FFS?**
 - HCBS as share of total LTSS spending
 - Rate of growth in per capita LTSS spending
 - Share of Medicaid LTSS beneficiaries using HCBS

Individual-Level Impact of MLTSS Programs

- **Do MLTSS programs improve access to services and care outcomes for people who need and use LTSS when switching from FFS to MLTSS?**
 - Changes in access to and use of HCBS
 - Changes in patterns of hospital and nursing home use
 - Changes in rate at which beneficiaries report usually or always getting the services and supports they need
 - Changes in receipt of appropriate preventive health care
 - Changes in quality of care

Impact of Different MLTSS Features

- **How do the effects of MLTSS programs vary by program features?**
 - Level of care criteria
 - Covered benefits
 - Rate setting

For More Information

- Debra Lipson, MLTSS Evaluation Lead
DLipson@mathematica-mpr.com
- Come to the National MLTSS Evaluation session tomorrow, September 1, 4:00 PM
- Read the Medicaid 1115 Demonstration Evaluation Design Plan on Medicaid.gov – *coming soon*
- First issue brief: “Who Enrolls in State MLTSS Programs? Implications of State Variation in Enrollee Characteristics for a Cross-State Evaluation” – *coming soon*



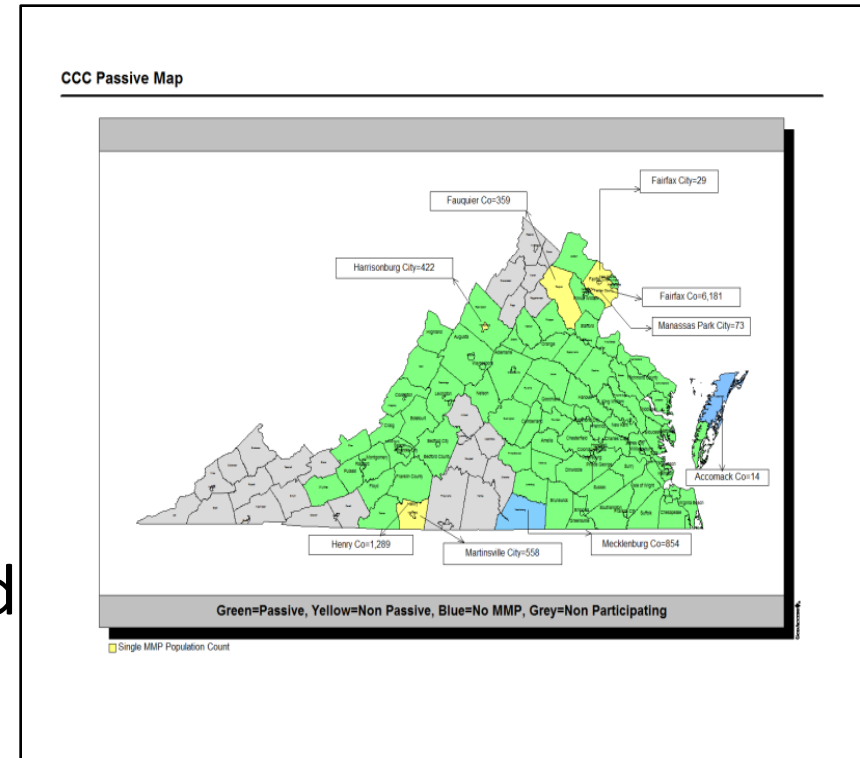
To Infinity and Beyond!!! Performance Monitoring of Virginia's MLTSS Program

Karen E. Kimsey, MSW
Deputy Director of Complex Care &
Services
HCBS National Conference
August 31, 2015

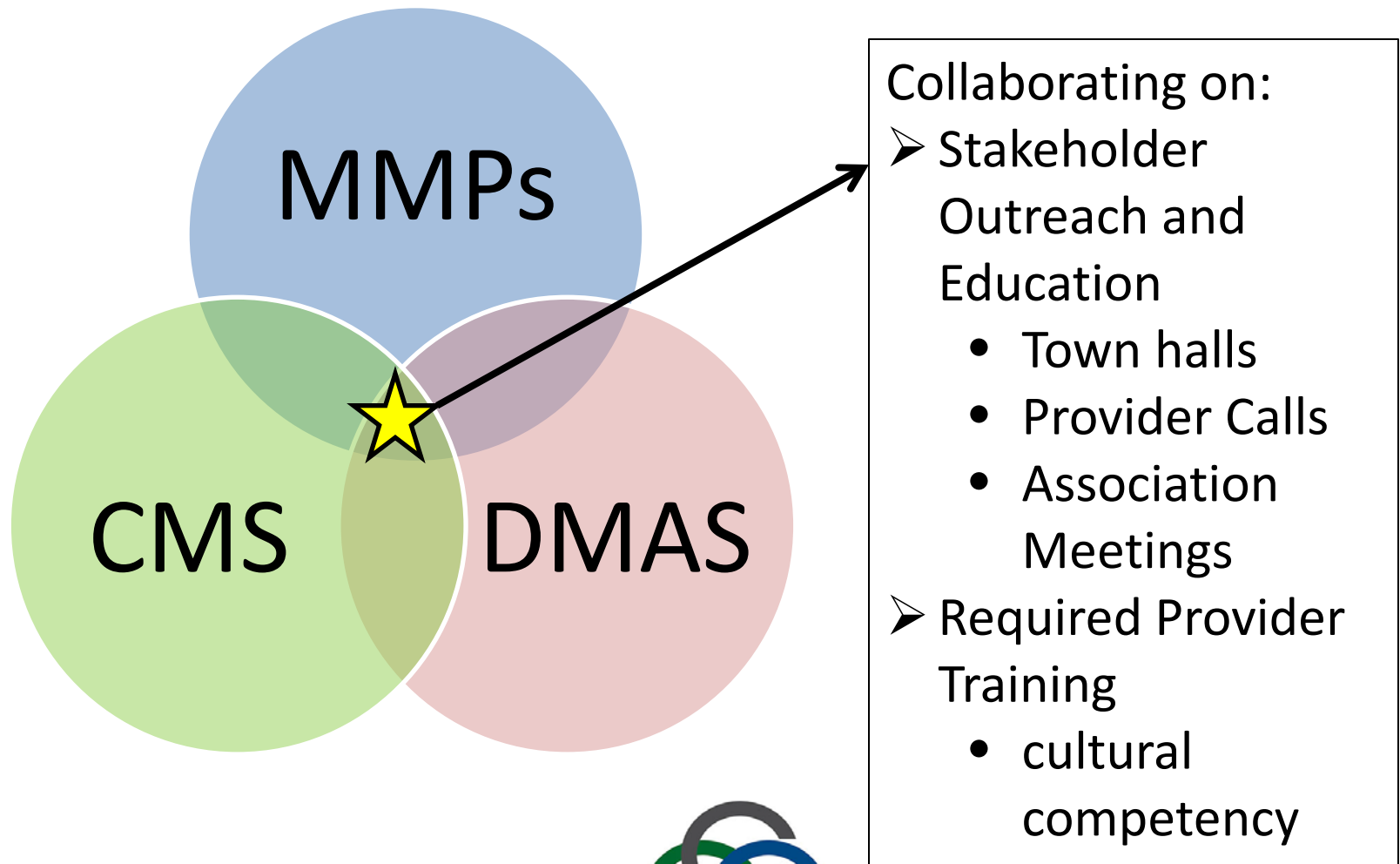


What is Commonwealth Coordinated Care?

- Virginia's Duals Financial Alignment Demonstration-Capitated
- Launched March 2014 – 29,000 Members
- MMP's (Medicare-Medicaid Plans)
 - Anthem Healthkeepers
 - Humana
 - Virginia Premier

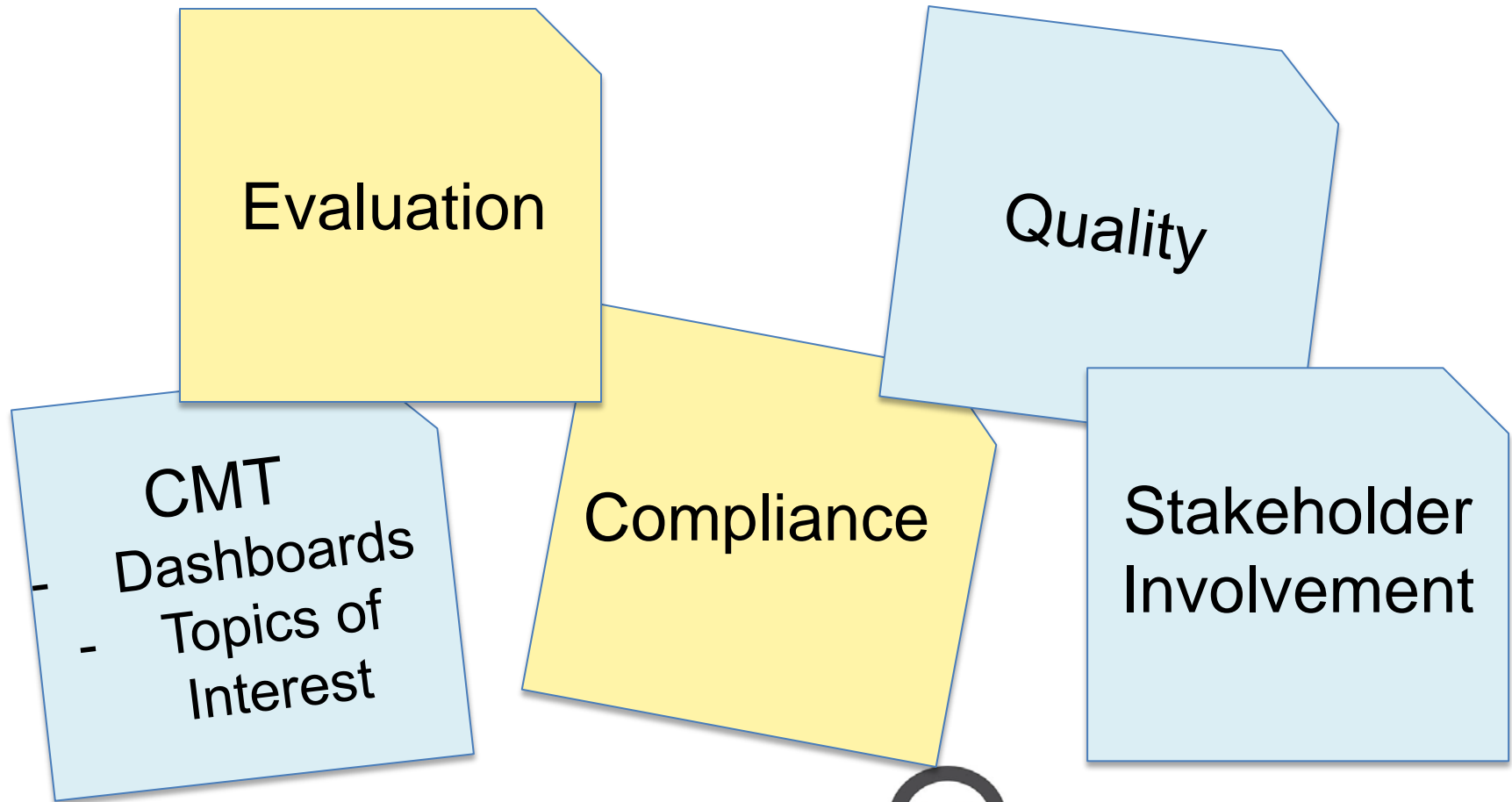


VA's Highly Collaborative Approach





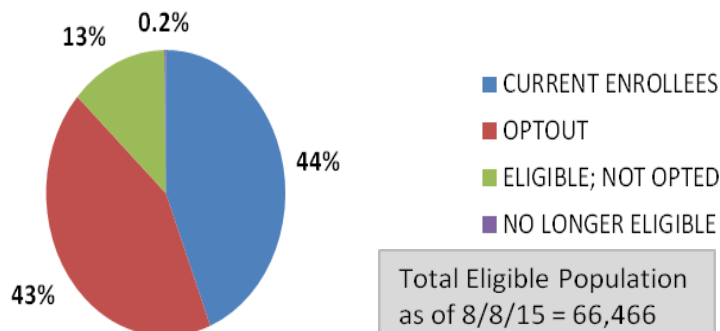
Methods for Assessing Performance and Program Improvement



Commonwealth Coordinated Care Monthly Enrollment Dashboard

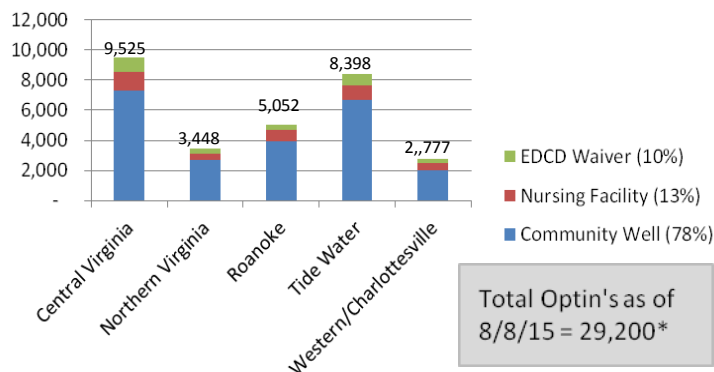
Through 8/08/2015

CURRENT ENROLLMENT STATUS OF TOTAL ELIGIBLE POPULATION



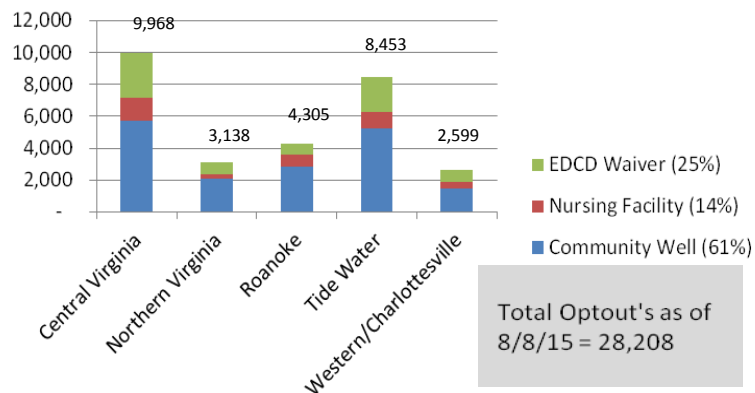
CURRENT ENROLLEES = All Active and Automatic Enrollments; **OPTOUT** = All potential enrollees that elected to not participate; **ELIGIBLE; NOT OPTED** = Potential enrollees that have not decided; **NO LONGER ELIGIBLE** = All potential enrollees that lost CCC eligibility because they lost Medicaid eligibility, moved out of the demonstration area, or because they now participate in some other exempt program or are in an exempt facility.

Optin By Region and Type



* Total Optin's includes prospective enrollment for September and October. As of August 8 there are a total of 1,946 prospective enrollments for those months.

Optout by Region and Type



Commonwealth Coordinated Care Monthly Enrollment Dashboard

Through 8/08/2015

CCC Enrollment By Plan and Region

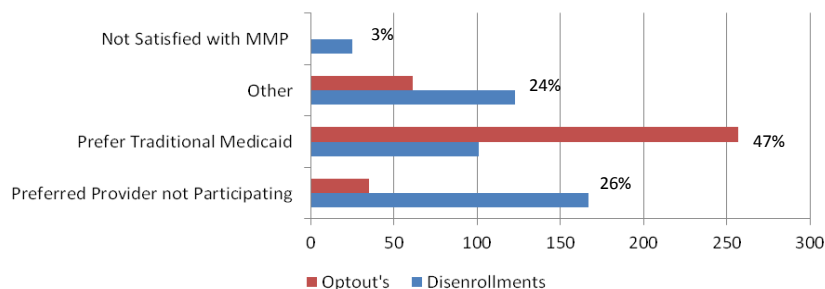
	Central Virginia	Northern Virginia	Roanoke	Tide Water	Western/ Charlottesville	Grand Total
Virginia Premier	2,636	58	1,216	1,489	719	6,118
Anthem HealthKeepers	3,681	1,750	1,806	3,770	1,241	12,248
Humana	3,208	1,640	2,030	3,139	817	10,834
Total	9,525	3,448	5,052	8,398	2,777	29,200

Maximus Call Center Statistics for July 2015

For Week Ending	Total Calls Received	Total Calls Answered	Total Calls Abandoned	Average Abandon Rate	Average Talk Time (minutes)	Average Wait Time (seconds)
7/10/2015	930	856	74	7.96%	6.7	71
7/17/2015	670	645	25	3.73%	6.4	21
7/24/2015	641	579	62	9.67%	6.3	38
7/31/2015	877	822	55	6.27%	5.2	26
Totals For Month	3,118	2,902	216	6.91%	6.2	39

Disenrollment and Optout's Reasons

06/29 - 7/31



CCC Enrollment Mailing

	30 Day Letter	60 Day Letter
Volume	962	1,214
Mailing Date	7/28/2015	7/28/2015



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Other = No reason given; Don't like change; Don't like CCC benefits; Pharmacy benefit not included; Co-pay too high; Too Complicated. Each is less than 5% of total Disenrollment's and Optout's. **Optout's** = left prior to service begin date. **Disenrollment's** = left after service begin date.



Other Performance Activities

- Observations (HRAs, ICTs, POCs)
- Meetings/Trainings with MMPs
- Onsite reviews and technical assistance
- Regular reports from State LTC Ombudsman (Department of Aging and Rehabilitative Services)

Care Coordination

- Heart of the program!
- Quarterly trainings based on observations and feedback
 - Pre/ post test, evaluation
 - Topics include MLTSS and contract requirements
- Currently holding monthly calls for the Care Coordinators for Q&A on various topics



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Quality

1

Reporting
metrics

2

State specific
reporting
methodology

3

PIPs and QIPs

4

Internal
Committee

5

MMP
Collaborative

6

Quality
stakeholder
workgroup



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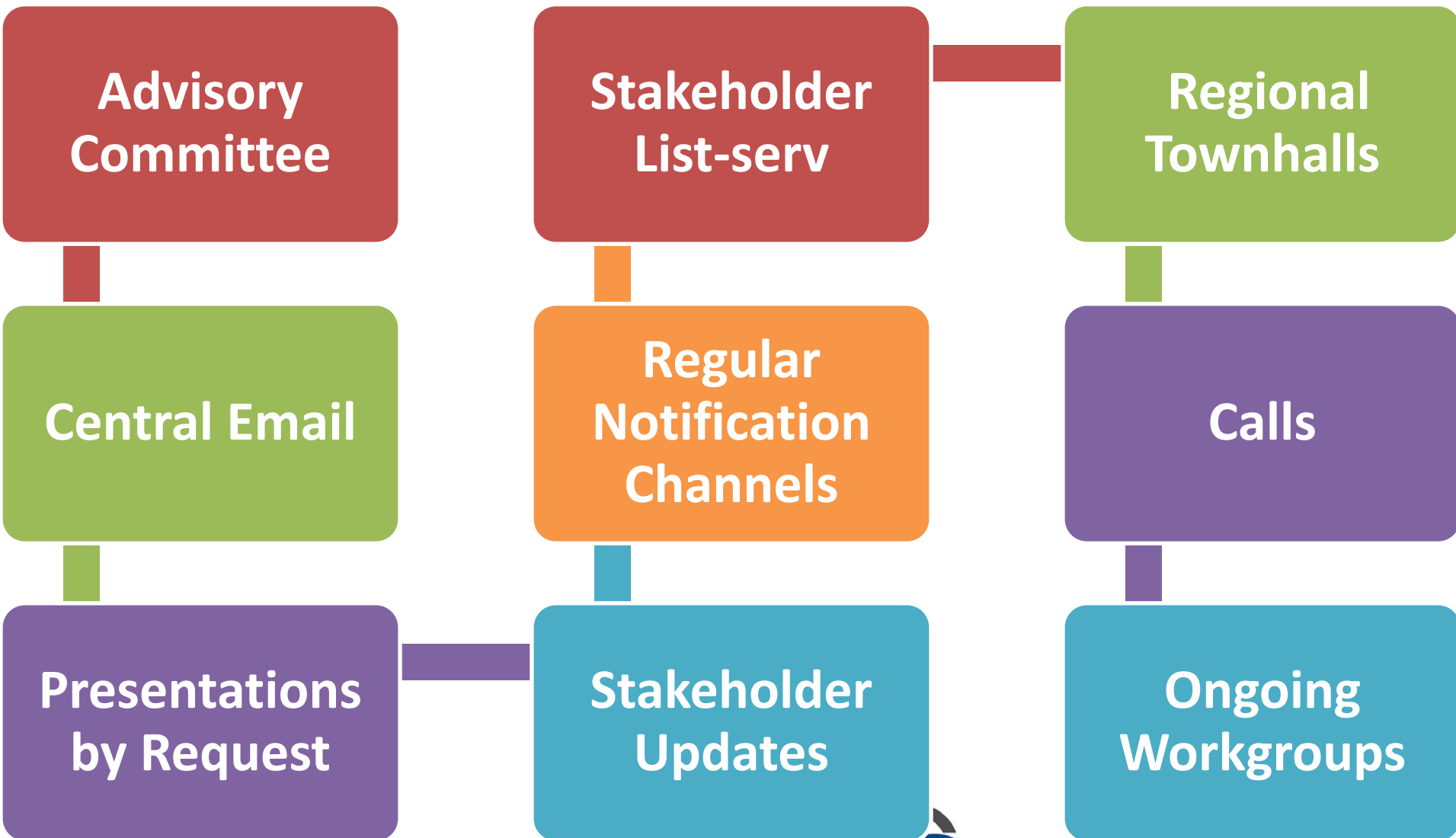


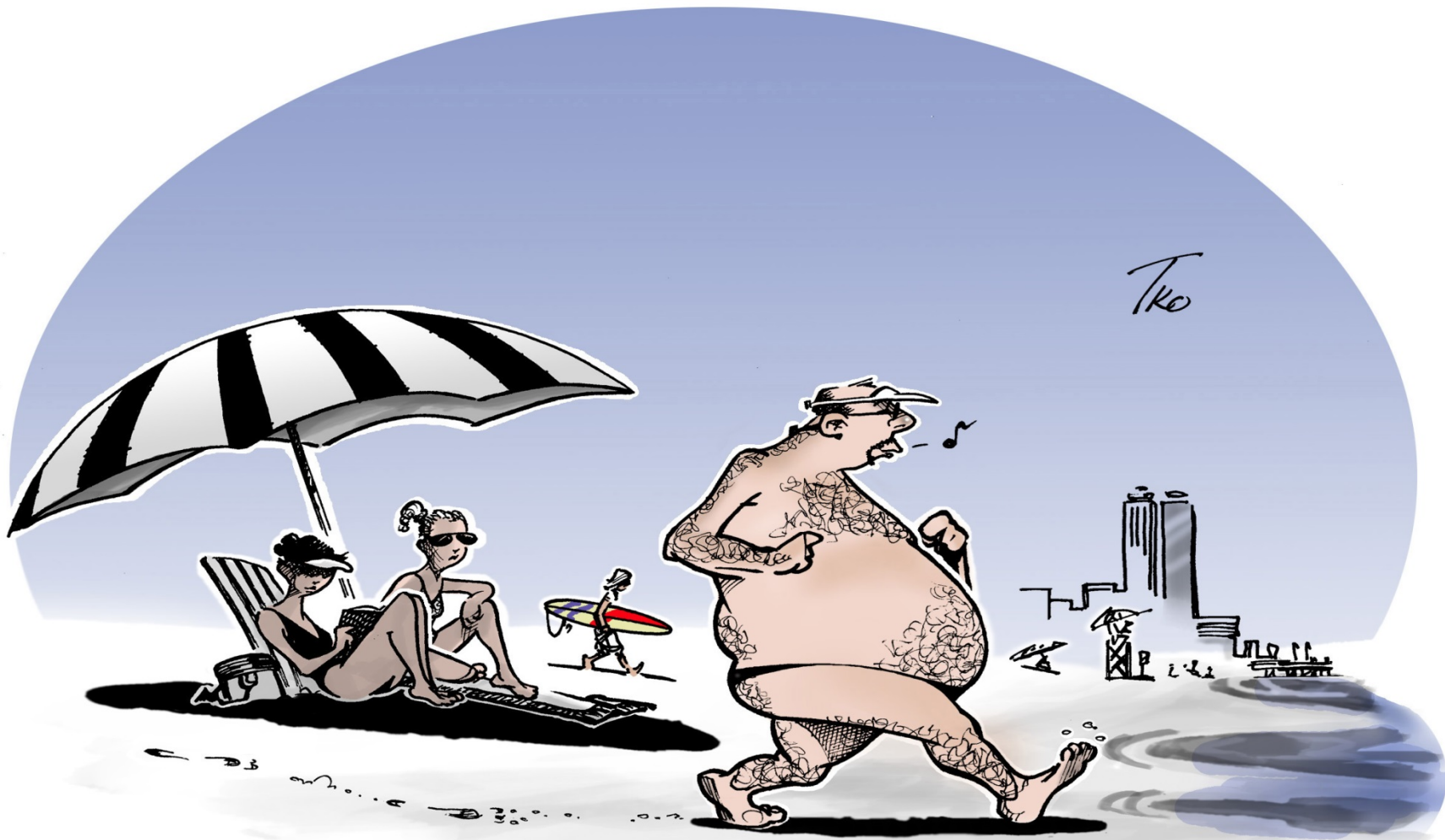
Evaluation Activities

- National level activities
 - RTI ([Virginia Evaluation Plan](#))
 - Kaiser Family Foundation Issue Brief: “Early Insights from Commonwealth Coordinated Care: Virginia’s Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries: <http://kff.org/medicaid/issue-brief/early-insights-from-commonwealth-coordinated-care-virginias-demonstration-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/>”
- [State level evaluation](#) (partnership with George Mason University)
 - Focus groups
 - Evaluation Advisory Committee
 - Observations (“Notes From the Field”)
 - Quarterly meetings with each MMP



Multi-faceted Stakeholder Engagement





“I’m no attorney, but that’s a material breach if I’ve ever seen one.”